AN EXPLORATION OF NARCISSISTIC VULNERABILITY IN RELATION TO THE BEGINNING PHASE OF TREATMENT

Mae Denton-Lewis

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We hereby approve the Clinical Dissertation

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DEDICATION

To my parents

Lee and Eloise Denton

TABLE OF CONTENTS

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Mae Denton-Lewis
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ABSTRACT

This study poses the question: "What are the specific factors in the beginning phase of psychotherapeutic treatment that are associated with the person's heightened state of narcissistic vulnerability?"

The purpose of this study is to explore theoretically the relationship of narcissism to self-esteem and to examine closely the ways in which both are affected by the vicissitudes of beginning treatment. Employing the Kohutian theoretical model of self psychology, in which narcissistic vulnerability is viewed as a logical outcome of the patient's precipitating problem, the author explores ways in which beginning treatment can pose further difficulty or cause narcissistic injury to an already vulnerable and troubled patient by forcing that patient to face the fact that now the problem has become so intense that he must turn outside himself for help. The author examines ways in which the already narcissistically vulnerable patient can receive further injuries via the private and particularly the public mental health clinic setting, with all its bureaucratic and impersonal procedures, and outlines both intrapsychic and extrapersonal factors which can affect the patient's self-esteem. The author presents a "List of

Factors" designed to sensitize therapists to their patients' narcissistic vulnerability and lowered state of self-esteem during the beginning phase of treatment.

Six case vignettes are selectively chosen from the author's clinical experience to illustrate and to explore these factors, and to support her thesis that almost all people have some degree of weakness in that part of their self that regulates self-esteem. Moreover, whatever the degree of this weakness, it intensifies during the beginning phase of treatment--a time generally marked by stress, anxiety and loss.

Based on the findings of the literature, the case vignettes, and the author's observations supported by her professional experience and judgment, the author concludes that factors both internal (intrapsychic) and external (extrapersonal) can have a profound and exacerbating effect on the patient's already vulnerable self at the beginning phase of treatment. Further, if this heightened state of vulnerability is not appropriately responded to by the therapist, the result may be the patient's premature discontinuance of treatment.

In light of the significant number of treatment failures during the beginning phase of treatment, the author recommends further and more conclusive research into the intrapsychic and extrapersonal factors that underlie

these treatment failures, particularly in the public mental health clinic setting.

CHAPTER I

INTRODUCTION

During the past three decades, psychoanalyst Heinz Kohut has put forth a continually developing model of self psychology which focuses on the intricate role of self-objects in the development of the self as well as in the maintenance of narcissistic equilibrium and self-esteem.

In this study, the author will utilize that Kohutian theoretical model of self psychology to explore the concept of heightened narcissistic vulnerability in the beginning phase of psychotherapeutic treatment.

The author of this study, though trained as a psychotherapist in the Freudian and ego psychological modes of theory and practice, was drawn to this Kohutian orientation through exposure to Kohut's theoretical model and through observation of patients in both a public mental health clinic and in private practice.

In the beginning phase of their treatments, the following phenomena were frequently observed:

1. A large number of prospective patients did not appear for their first scheduled appointment.

2. Many patients began treatment but abruptly discontinued after one or a few sessions.

3. In the initial session many patients appeared to be anxious and ambivalent about engaging in treatment. Some patients questioned the need for therapy, expressing concerns that the therapist's valuable time was being wasted. Other patients identified the overt problem but then denied the presence of elaborating thoughts.

4. Finally, it appeared that those patients who "survived" for more than three or four sessions were more likely to remain in treatment.

Kohut offered an explanation for these resistances to treatment in 1970 when he lectured on the topic of "Narcissism as a Resistance in Psychoanalysis." He said that "the resistance is a function of the general narcissistic vulnerability of the patient . . ." and is motivated by the patient's anxieties about treatment, not by specific unconscious instinctual wishes or specific pathogenic infantile narcissistic needs. Kohut further explained that patients resist treatment because ". . . analytic treatment as a whole offends . . . [their] . . . pride . . . and contradicts [the] fantasy of . . . independence." This response, Kohut said, was true for the patient regardless of the "specific details of his psychic illness" (Kohut in Ornstein, pp. 547-549).

Further, Kohut points out that most classical analysts recognize that patients have a general "non-specific" resistance to analytic treatment which is directed against the analytic process as a whole. This nonspecific resistance is not an outgrowth of the patient's unresolved oedipal conflicts, nor is it because of specific deficits in the narcissistic realm of his personality. The resistance is in response to the patient's general narcissistic vulnerability to treatment as a whole.

Although patients who have specific deficits in their self development are significantly more susceptible to narcissistic injuries, self psychology, as presented by Kohut (and later expanded by Goldberg, Ornstein, Wolf and Palombo et al.) would depart from classical analytic theory in supporting the premise that almost all people have some degree of weakness in that part of their self that regulates self-esteem. Moreover, whatever the degree of this weakness, it intensifies during beginning treatment, a time marked by stress, anxiety and loss.

This study, therefore, will address and explore these "resistances" to beginning treatment from the perspective of the patient's heightened state of narcissistic vulnerability. Thus, the patient's initial anxiety and fear about treatment, which may be manifested by cancellation of appointments, lateness to sessions, and overall

ambivalence about treatment, may arise out of his narcissistic vulnerability and the ensuing state of reduced self-esteem.

This study does not suggest that all resistances that arise during the beginning phase of treatment are caused solely by the patient's narcissistic vulnerability. It is, however, the author's contention that most patients exhibit some degree of narcissistic vulnerability and lowered self-esteem in beginning treatment. If this vulnerability is misunderstood and subsequently improperly probed for unconscious, repressed feelings, the most important aspect of the patient's feelings may be missed--that is, his narcissistic injuries resulting from various factors associated with beginning treatment.

Moreover, since the author is a clinical social worker who has practiced psychotherapy both in a private practice and in a public mental health clinic setting, the study will address a new and perhaps previously unexplored premise: that the patient's narcissistic vulnerability can be affected not only by inner factors associated with beginning treatment but by external ones as well, i.e., the patient in a public, bureaucratic clinic, with all its red-tape and lack of privacy, is more likely to suffer narcissistic injury than the patient in a private practice setting.

Statement of the Problem

Narcissistic vulnerability, a psychological state of reduced self-esteem or self-regard, is often overlooked as a critical dimension in the beginning phase of psychotherapeutic treatment.

All too frequently, whether their therapy be in a mental health clinic, a social service agency, or in a private practitioner's office, prospective patients suffer inadvertently inflicted narcissistic injuries by therapists and/or clinic staff; other circumstances in conjunction with beginning treatment that occur outside the treatment session can inflict injury as well. These injuries must be recognized and dealt with appropriately by the therapist or the vulnerable individual may turn away from treatment before a therapeutic relationship can be established and the needed help can be received.

This study will explore three issues that are believed to be associated with the patient's heightened state of narcissistic vulnerability in beginning treatment:

1. Patient Self-Esteem

Most patients are in a state of lowered self-esteem when they initially decide to engage in psychotherapeutic treatment. This emotional state is what

precipitated their seeking of psychotherapeutic help.

2. The Initial Therapeutic Experience

This involves the often devastating experience of acknowledging one's inability to deal with one's problems alone and one's need for the assistance of a professional. The mere presence of this professional--who is perceived as superior--promotes the feeling that the patient himself is hence inferior.

3. Injuries Inflicted from Outside the Treatment Session

These injuries occur in both private practice and in the clinic setting, however, they appear to be more intense and numerous in the clinic setting. Such injuries can result from the location or atmosphere of the office or clinic, patients' observations of each other, the attitudes of the ancillary staff, the attitude of the therapist who is to conduct the treatment, or the complex bureaucratic procedures required of an intake therapist which can create a sense of trust and subsequent betrayal.

In this study, the beginning phase of treatment is defined as that period of time from the patient's first contact with the receptionist or the therapist through the beginning establishment of a trusting relationship with the therapist. This trusting relationship is

experienced by the patient as a feeling of rapport with the therapist. Although this rapport is tenuous and fragile, the patient begins to feel understood by the therapist in an accepting and non-judgmental way. Hence, as a result of the therapist's non-judgmental responsiveness to the patient's attitudes and feelings, the patient begins to feel emotionally connected with the therapist.

Ideally, the establishment of this patient-therapist rapport should begin by the end of the first session.[1] Frequently, however, a minimum of three or four sessions may be required. In any event, one can say with considerable confidence that the longer this trusting relationship takes in forming, the greater the likelihood that the patient will not continue in treatment. In order to minimize narcissistic injury, therefore, it is vital that the therapist be sensitive to the patient's heightened state of narcissistic vulnerability during this crucial time in treatment. Numerous consequences may occur if this vulnerability is not addressed, not the least of which is that the person may discontinue treatment.

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[1]This trusting therapeutic relationship is not to be confused with the "working alliance" defined by Ralph Greenson and which he says takes from three to six months to form.

Purpose of the Study

It is the author's belief that the reasons for patients' resistance to psychotherapeutic treatment have not been adequately explored. The literature reveals that minimal emphasis has been placed on the specific issue of patients' susceptibility to narcissistic injury during the beginning phase of treatment. The existing material is sparse and incomprehensive. Numerous references discuss the patient's fear and anxiety in relation to beginning treatment but they do not conceptualize these factors as being related to the patient's narcissistic vulnerability. As a result, clinicians are prone to mislabel and misunderstand the patient's feelings and subsequent behavior.

Most authors who direct their writing to the above issues go on to say that these fears, resistances or vulnerabilities, must be dealt with in order for treatment to ensue. Frequently, suggestions concerned with technique are offered. However, the why of the patient's narcissistic vulnerability has not been satisfactorily explained and dealt with.

Therefore, the purpose of this study will be (1) to explore and expand the theory that relates to the patient's heightened state of narcissistic vulnerability during the beginning phase of treatment; (2) to enhance the understanding of therapists as well as mental health

administrators, regardless of their theoretical persuasion, so as to better help patients during this critical phase of treatment, and finally (3) to compile a List of Factors for therapists that can alert them to the signs of their patients' narcissistic vulnerability during beginning treatment.

Significance of the Study

This study will represent a documented analysis and synthesis of theory that is relevant to patients' narcissistic vulnerability during the beginning phase of treatment. It is hoped that the study will result in an expansion of the present knowledge. Phenomena that are traditionally viewed as "resistances" to treatment will be identified and further explored from the realm of both the patient's vulnerable and injured self as exemplified by self psychology. In sensitizing therapists of all theoretical persuasions to the narcissistic vulnerability of patients during beginning treatment, it is hoped that therapist-induced treatment failures will be reduced and that patients will be enabled to tolerate this difficult phase of treatment.

Furthermore, it is anticipated that mental health administrators will utilize this information in structuring mental health programs--particularly the intake process.

Although the theory and case vignettes to be used in this study will be, for the most part, explored in light of the author's experience as a psychotherapist in private practice and in a public mental health clinic, it would appear that the same issues would be relevant to people seen by caseworkers in public or private social service agencies.

It is anticipated that the issues which evolve out of this study will generate hypotheses that will serve as the basis for further studies.

Limitations

The observations and conclusions to be reached in this study will be influenced by the author's work with adults and adolescents that she either worked with or observed in private practice or public clinic settings. No children will be studied.

The clinical vignettes will be selected and presented subjectively--that is from the author's clinical experiences--in order to illustrate and support the theoretical data and premises.

The literature will be selectively chosen from that body of material which enhances the understanding of the subject of narcissistic vulnerability during the beginning

phase of treatment, and will support the author's contentions in that regard.

Overall, although the author has worked psychotherapeutically with patients with a wide range of presenting and continuing problems, only factors related to narcissistic vulnerability during beginning treatment will be examined. This necessarily also involves the author's clinical judgment because it is not always possible to learn the full range of underlying reasons for specific responses from patients.

Organization of the Study

The study will be organized in the following manner. This introductory chapter has been presented as an overview of the study, including a statement of the problem, purpose and significance of the study, limitations, organization and definition of terms.

Statement of the central research question and the methodology will be reviewed in Chapter II. The review of the literature, discussed in Chapter III, is categorized into the three constituents of the research question:

1. Narcissism: Freud and Kohut and their respective followers.
2. Beginning treatment: Paramount issues.

3. Narcissistic vulnerability in beginning treatment.

Kohut's psychology of the self will be the theoretical frame of reference used in this study as presented in Chapter IV. The pertinent constituents of self psychology that apply to this study will be delineated. To illustrate the contentions of the study, six case vignettes will be presented and discussed in Chapter V. A discussion of the author's thinking based on her knowledge and clinical experience as related to the research question and the purpose of the study will be presented in Chapter VI. A List of Factors will be compiled in Chapter VII to help sensitize therapists as well as administrators to the narcissistic vulnerability of patients. In Chapter VIII the predominant themes and their implications for treatment will be summarized. Recommendations for treatment and further study will be made.

Definition of Terms

Self

Kohut defines the self as the core of the personality which is developed in response to the interplay between the child's narcissistic needs and the important people--selfobjects--in the child's environment.

Narcissism

The general use of the term narcissism refers to self-love or the psychological investment in one's self. Various other facets of narcissism are referred to in the Review of the Literature and are defined in context.

Primary Narcissism

Freud defined primary narcissism as the normal stage of narcissistic development which lies between the stages of auto-erotism and object-love and which is characterized by libidinal investment in the self or ego. This self-investment occurs prior to the child's first investment in external objects.

Secondary Narcissism

According to Freud, secondary narcissism occurs after there has been a libidinal investment in external objects. Because of disappointments or illness, the child withdraws libido from external objects and redirects the investment back on the self.

Selfobject

A selfobject, as described by Kohut, is an object or person whom the child experiences as a part of the self. The selfobjects provide two basic age-appropriate narcissistic functions for the child. The first is the

"mirroring" function and the second is the function of the "idealized parent imago."

The mirroring selfobject "responds to and confirms the child's innate sense of vigor and perfection." The idealized parent imago is experienced as someone ". . . to whom the child can look up and with whom he can merge as an image of calmness, infallibility and omnipotence" (Kohut and Wolf, 1978). If the functions of these self-objects are not internalized by the child, he will continue into adulthood seeking people who will perform these functions for him. Without the needed selfobject functions, the adult's narcissistic equilibrium will be vulnerable.

Self-Esteem

For the most part, self-esteem is used synonymously with narcissism--that is, the capacity to feel joy, pride and enthusiasm about one's self. Self-esteem is achieved via a "stable balance between one's goals and ambitions . . . that permits the actualization of one's potential, one's skills and talents . . ." (Palombo, 1979c).

Narcissistic Vulnerability

A psychological state of reduced self-esteem or self-regard.

Narcissistic Injury

An injury to one's narcissism--or self. This injury will be viewed as a separate psychological phenomenon that most people are susceptible to during times of anxiety, stress and loss--regardless of their personality structure.

Beginning Phase of Treatment

That time from the patient's first telephone contact with the clinic or therapist until the beginning establishment of a trusting therapeutic relationship. This relationship ideally is formed by the end of the first interview; however, frequently three or four sessions are required.

The Clinic

The clinic is a large, multidisciplinary, county-operated, adult outpatient clinic.

Intake Session

This is the patient's initial psychotherapeutic interview at the clinic.

Trusting Therapeutic Relationship

This relationship is experienced by the patient as a feeling of rapport with the therapist. The patient feels that the therapist is understanding, accepting and

non-judgmental of his feelings. A sense of emotional connectedness ensues.

Empathy

Kohut describes empathy as the capacity for the therapist to understand the patient's thoughts or feelings through the use of introspection. There is a temporary psychological merger with the patient in an attempt to understand his feelings. Empathy does not simply mean that the therapist is "kindly, warm, and accepting." Palombo states that the self psychological "redefinition of empathy removes those qualities from the [overt] activity and limits the activity singly to one of observation without judgment, much like the eye sees, the ear hears, human beings empathically introspect and grasp others' internal states" (1980a).

For the purpose of this study a therapist is believed to be empathic when he uses the empathic mode of observation to understand the patient. Further, a response is considered to be empathic when the therapist conveys verbally or non-verbally his empathic understanding of the patient.

Sympathy

This term is used throughout the review of the literature. It is not to be confused with empathy.

Although this author cannot be responsible for the definitions of other writers, it is assumed that sympathy means--feelings of compassion, objective identification, and friendliness.

CHAPTER II

CENTRAL RESEARCH QUESTION AND METHODOLOGY

Central Research Question

This study will address and explore the following question: "What are the specific factors in the beginning phase of psychotherapeutic treatment that are associated with a person's heightened state of narcissistic vulnerability?"

Constituents of the Question

Very limited data are available in the literature regarding the issues of narcissistic vulnerability during the beginning phase of treatment. Therefore, to focus the study, the central research question will be divided into the following three basic constituents:

Part 1. Narcissism: as formulated by Freud and Kohut, and their respective followers.

Part 2. Beginning Treatment: paramount issues.

Part 3. Narcissistic vulnerability in beginning treatment.

Methodology

Three sources of data will be used:

1. The relevant psychoanalytic and social work literature.

2. Case vignettes selected from the author's clinical experience.

3. The author's clinical expertise and convictions based on her empathic observations of patients during beginning treatment, and information derived from patients during the ongoing treatment process.

Literature

Because the existing literature about patients' narcissistic vulnerability in beginning treatment is sparse, the topic will be explored by examining the literature relevant to the three aforementioned constituents of the research question.

The objective of Part 1 in the Review of the Literature will be to clarify the concept of narcissism according to (a) Freudian theory, (b) modifications of Freudian theory including ego psychology and object relations theory, and (c) Kohutian theory.

With each theory, focus will be on: (a) the definition of narcissism, (b) the role of narcissism in personality development, (c) the nature of narcissistic

vulnerability in the adult, and (d) an explanation of the mechanism of narcissistic injury in the adult.

The purpose for exploring these major theories regarding narcissism will be:

1. To gather data supporting the premise that most adults, regardless of their personality structures, can be susceptible from time to time to narcissistic injuries, particularly during times of extreme stress, anxiety or loss.

2. To provide the clinician, regardless of his or her theoretical persuasion, with a description of the various types of possible narcissistic injury states that can be identified and dealt with in the therapeutic setting.

The objectives of Part 2 of the literature which addresses the earliest aspects of the initial phase of treatment, will be to examine how the patient's narcissistic vulnerability and lowered self-esteem might be impacted by such an issue as the therapist's goals for the initial interviews versus the patient's needs.

The focus will be on (a) two basic schools of thought regarding the purpose of the initial interview, and (b) paramount issues in the initial interviews, including attitudes in the basic schools of thought concerning the patient-therapist relationship.

In Part 3 of the Review of the Literature, references relating to patients' narcissistic vulnerability in beginning treatment will be extracted and examined.

Case Vignettes

Using Kohutian theory as a frame of reference, six case vignettes will be presented and discussed. These vignettes were specifically selected from the author's clinical experience and examined retrospectively for the purpose of illustrating the author's theoretical contentions about patients' heightened state of narcissistic vulnerability during the beginning phase of treatment.

Each case presentation will demonstrate significant material which shows evidence of the patient's narcissistic vulnerability during the initial contacts with the therapist.

Succeeding each case presentation will be a theoretical discussion. Focus will be on intrapsychic and extrapersonal factors which related to the patient's narcissistic vulnerability.

Intrapsychic factors will be those narcissistic vulnerabilities that brought the patient to treatment, including lowered self-esteem and wounded narcissism.

Extrapersonal factors will be those narcissistic injuries that occur in response to the treatment setting,

the ancillary staff or the therapist who may be required to follow certain clinic procedures over which he has no control. Most frequently these injuries occur outside the treatment session.

The Author's Clinical Expertise

The author's therapeutic expertise and knowledge of self psychology will be utilized throughout the study, particularly in Chapters V and VI. In Chapter V the author's case vignettes will be used to illustrate the premises of the study. Chapter VI will include a discussion and amplification of the findings.

This discussion will culminate in a List of Factors in Chapter VII designed to assist the therapist in identifying and addressing the patient's possible areas of narcissistic vulnerability or injury, including the presence of: (a) lowered self-esteem, (b) hurt pride, or (c) hurt feelings.

CHAPTER III

REVIEW OF THE LITERATURE

Part 1
Narcissism as Formulated by Freud and Kohut and their Respective Followers

This section of the Review of the Literature provides the clinician with an overview of the term narcissism as formulated by Freud and those who expanded his theory--the ego psychologist and object relations theorists--and by Kohut and other self psychologists. It also outlines how these various theorists distinguish between pathological and normal narcissism and sets the stage for an understanding of the key role that narcissism plays in the beginning phase of treatment.

Evolution of Freud's Thoughts

Freud coined the term narcissism, meaning self-love, from the British psychologist and writer, Havelock Ellis, who described in his works on human sexual behavior the mythological Greek youth, Narcissus, who, looking into a pond fell in love with his own reflection.

Freud first wrote of narcissism in his Three Essays on the Theory of Sexuality (1905). Here, narcissism was

described as a fixation in the libidinal[1] development of homosexuals or "inverts."

In The Case History of Schreber (1911), and in Totem and Taboo (1913), Freud expanded his formulations of narcissism in two ways: (1) Narcissism was used as a term to mean the use of the ego[2] as a libidinal or love object, and (2) as the stage of libidinal development which occurs between the stages of auto-erotism and object-love.

In The Case History of Schreber (1911), Freud explained the nature of narcissism in the following way:

> There comes a time in the development of the individual when he unifies his sexual instincts (which have hitherto been engaged in auto-erotic activities) in order to obtain a love-object; and he begins by taking himself, his own body, as his love-object, and only subsequently proceeds from this to the choice of some person other than himself as his object (p. 163).

Freud further stated that perhaps this stage of narcissism may be indispensable to normal personality development; but he held that if the person lingers too long in this stage, his later personality structure will be marred by self-absorption and the inability to invest in others. Homosexuals and schizophrenics were cited as

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[1]The energy of the sexual drive.

[2]In Freud's early writings he used the terms ego and self synonymously. The ego was not yet formulated as an autonomous system.

examples of individuals who had not proceeded out of narcissism to the stage of object-love. These narcissistic individuals were believed to have withdrawn libidinal investment from the outside object-world and returned to a state of cathexis or investment in the self or the ego.

In Freud's most comprehensive paper on the subject entitled On Narcissism: An Introduction (1914), he defined narcissism as the libidinal investment of the ego. In Freud's view narcissism was a pejorative term because the ego investment resulted from the person's defensive withdrawal of libidinal investment in others.

Freud (1914) postulated two types of narcissism, primary and secondary.

He defined primary narcissism as the normal stage of development between auto-erotism and object-love, where libido is invested in the self prior to the first investment in external objects. In contrast, secondary narcissism occurs after there has been libidinal investment in external objects. However, because of trauma or severe disappointment in the object, the person withdraws libidinal attachment to significant others and redirects the investment back onto the self.

Freud (1914) also discussed the self-regarding attitude in normal and neurotic people. He wrote that "self-regard appears to . . . be an expression of the size

of the ego. Everything a person possesses or achieves, every remnant of the primitive feeling of omnipotence which his experience has confirmed, helps to increase his self-regard" (p. 98). Self-regard, Freud continued, has an "intimate dependence on narcissistic libido . . . ." It is a fundamental fact in Freud's view that " . . . in love-relations, not being loved lowers the self-regarding feelings, while being loved raises them." He further stated that the "aim and satisfaction in a narcissistic object-choice is to be loved" (p. 98).

Modifications of Freudian Theory, Including Ego Psychology and Object Relations Theory

Hartmann, considered to be the father of ego psychology, attempted to integrate Freud's early formulations on narcissism into Freud's later structural and dual drive theory, a task which Freud himself did not complete.

Hartmann (1950) followed Freud with a modification of Freud's definition of narcissism. Rather than defining narcissism as the libidinal cathexis of the ego (a psychic system), as Freud advocated, Hartmann defined it as the "libidinal cathexis of the self" (one's own person) and, parenthetically, he further clarified that "it might also be useful to apply the term self-representation as opposed to object representation" (p. 85). Hartmann went on to say that it is not the person or object that is cathected,

as Freud believed, but the mental representations of that object.

Later, Hartmann (1952) elaborated on this point as paraphrased by Mahler (1966):

> The two pillars of early infantile well-being and self-esteem are the child's belief in his own omnipotence and his belief in the parents' omnipotence, of which he partakes; these beliefs can be replaced only gradually by a realistic recognition of, belief in, and enjoyment of his individual autonomy, and by the development of object constancy (p. 60).

Hartmann's theory suggests that the narcissistic adult is one who experiences frustrations and narcissistic injuries as a result of an impaired capacity to employ defenses and to neutralize his aggressive drives. That is--the ego is hindered in its capacity to assume its organizing role and to mediate between the drives and reality. The extreme of this limited ego function would result in a psychosis.

Gertrude and Rubin Blanck, present-day ego psychologists, who have synthesized the works of prominent ego psychologists and object relations theorists, borrowed from Hartmann in clarifying that "neutralized aggression is the energic source for the defense mechanisms. The ego that cannot employ defense is . . . seriously impaired" (Blanck and Blanck, 1970, p. 34).

Whereas Hartmann viewed narcissism predominantly in terms of its impact on ego development, Jacobson (1954), an object relations theorist, shifted the focus away from seeing narcissism as solely drive-related or structure (ego) building, the view held by Freud and Hartmann, respectively. Jacobson (1954) developed the idea of narcissism as a type of object-relationship, illustrating with extensive discussions concerning the quality of the child's relationship with the mother or other significant external objects.

Jacobson (1964) explained that through the process of "selective identification" the child develops a self-cohesiveness and security which enables him or her to separate physically and psychically from the mother. During this process the child identifies with the object as an ego-ideal and then internalizes select mental representations of that object.

In the following quote, the Blancks (1970) summarize Jacobson's view of the role of parental love as it applies to this process of selective identification:

> Parental love combined with tolerable degrees of frustration and prohibition promote the establishment of stable, enduring libidinal cathexes of the self and objects and make for normal ego and superego formation and for independence. Necessary frustration teaches the child to relinquish infantile magical expectations as well as preoedipal and oedipal sexual strivings. It arouses ambivalence toward the frustrators, resulting in accumulation of aggression toward them and of libido toward the self, which in turn stimulates progressive forms of identification with the parents and promotes ego

> autonomy by enhancing narcissistic endowment. Overgratification and severe frustration induce regressive fantasies and reunion of self and object and thereby delay development (p. 65).

The Blancks (1979a) point out that this thinking marked a new trend in the formulation of narcissism. Jacobson, they say, believed that the child could love himself as well as the object--indeed--this self-love was necessary for the development of a healthy personality.

In a tape-recorded seminar, the Blancks (1979b) discuss Jacobson's new thinking in terms of self-esteem. They explain that love extends from a normal regard for oneself to a normal regard for others. Self-esteem, they define, as "the capacity to endow the mental representations of the self with positive affective values." The individual, they continue, has mental images both of himself and of external objects. Through identification with these mutual images, the individual endows his own self-representations with those images.

Though Jacobson focuses on positive aspects of narcissism in self-esteem she also finds a place in her schema for pathological narcissism. According to Jacobson, if the child is met with too severe disillusionment or abandonment before firmly establishing the boundaries between self and object representations, he may develop a brittle equilibrium which will be vulnerable when disappointments are

experienced in later life. The most grave outcome of this early trauma would be severe fragmentation or psychosis.

One would expect, however, that minor disturbances might lead only to temporary regressive states in the healthier adult.

Mahler (1975) elaborates on these concepts of identification and self-esteem. She states that during secondary narcissism[1] the infant takes both his own body and his mother's body as the object and it is only then, with sufficient symbiotic loving care, that the child is gradually able to separate from the mother and subsequently identify with her.

Mahler (1966) further explains how injuries to the child's self-esteem are prevented:

> The mother's . . . acceptance and active support during the rapproachment phase is . . . a necessary prerequisite for the toddler's gradual realization and acceptance of the unreality of his 'omnipotence'--a realization which will allow the secondary narcissistic investment in his own autonomy to take place gradually, thereby protecting him against acute deflation of his 'omnipotence' and preventing serious injury to his self-esteem (p. 69).

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[1]Mahler views secondary narcissism as a normal developmental stage which begins in about the second month of life during the differentiation subphase and proceeds throughout separation-individuation.

We see thus far how, beginning with Freud, narcissism was viewed as a negative phenomenon in personality development. Freud believed that if one invested too much energy in one's self that he would have insufficient energy to invest in others. He further viewed secondary narcissism as growing out of a defensive withdrawal of libidinal attachments to significant others following trauma or severe disappointments and was, therefore, considered to be pathological.

Hartmann (followed by Jacobson and Mahler) expanded Freud's early formulations on narcissism into Freud's structural theory and then proceeded with their own contributions concerning the role of narcissism in the development of the ego and object relations.

Hence, through the works of these theorists, narcissism was now no longer looked at only in a negative way. The consensus was now that in order for a person to have positive self-esteem he must love himself as well as others.

Kohut and His Followers

Despite these elaborations and ameliorations, Kohut takes issue with the Freudian, ego psychological and object relations points of views about narcissism and self-esteem.

He states that it is the nature and quality of the child's experiences with the parental figures as self-objects that are important to the healthy development of narcissistic equilibrium and self-esteem. By nature of the selfobject, Kohut is referring to whether the parent as the selfobject is providing the "mirroring" or "idealizing" function for the child. And by quality, he is referring to the way in which the child experiences the needed narcissistic functions performed by the parental figures as selfobjects.

For example, we can ask the questions: Did the child experience soothing and tension regulation from the idealized parent? Were his age-appropriate needs for attention and admiration satisfactorily met?

Kohut (1971) refers to the internalization of these functions of the selfobjects and not to the internalization of the self-representations. He believes that through the process of "transmuting internalization" the child gradually becomes able to perform the functions of the self-objects for himself. The child is then better able to regulate his grandiosity into positive self-esteem.

Offenkrantz and Tobin (1978) succinctly summarize and partially quote Kohut's (1968) concepts of narcissism:

> 'Under optimum developmental conditions, the exhibitionism and grandiosity of the archaic grandiose self are . . . tamed, and the whole

> structure ultimately becomes integrated into the adult personality.' There it is manifested by our healthy ambitions and the self-confidence to achieve them; enjoyment of our activities; humor characterized by an ability to laugh at our own shortcomings; empathy; and important aspects of our self-esteem. 'Under similarly favorable circumstances, the image of the idealized parent also becomes integrated into the [healthy] adult personality.' It provides the sense of pleasure we derive in obeying the dictates of our conscience as well as in living up to 'the guiding leadership of its ideals.' Eventually, it provides us with the capacity for a mature form of admiration for others and for enthusiasm about our own achievements (p. 604).

Kohut (1968) states, however, that to the degree that these needs are not satisfied in childhood, the adult will suffer narcissistic vulnerability and correspondingly limited capacity for self-esteem and for self-soothing or tension-regulating functions.

Kohut and Wolf (1978) indicate, however, that even people with relatively healthy mature cohesive selves may be vulnerable to narcissistic injury. They write that:

> Occasionally occurring fragmentation states of minor degree and short duration are ubiquitous. They occur in all of us when our self-esteem has been taxed for prolonged periods and when no replenishing sustenance has presented itself (p. 418).

People with pronounced deficiencies in their cohesive selves, they continue, will respond severely to even minor disappointments.

Although, as we have seen, there are numerous concepts about narcissism in the literature, there is a

general consensus among the self psycholgists that narcissistic injury may be defined as a "psychological injury to one's self or self-esteem" (Goldberg, 1973, p. 722).

Part 2
Beginning Treatment: Paramount Issues

Narcissistic injury, as defined by Kohut and other self psychologists (Part 1 of the Review of the Literature) and as utilized by the author in this study, is "a psychological injury to one's self or self-esteem."

In this part of the Review of the Literature, it is appropriate to examine issues concerning that phase of the treatment in which narcissistic vulnerability and narcissistic injury are most likely to occur: the beginning phase of treatment.

By gaining a better perspective of the paramount issues in this phase of treatment--particularly from the point of view of the therapist's goals in the initial interviews--we will be able to see what impact they can have on the narcissistically vulnerable patient.

When compared to the overall material written about psychotherapeutic techniques, the literature on the beginning phase of treatment is scanty. Most of the available material focuses predominantly on the initial interview and is found under headings such as the "Initial Interview" or the "Psychiatric Interview." Information,

however, is embedded throughout the literature extending this initial process to include one to several interviews. It is implied by many authors that their reference to the initial interview extends until the history and diagnosis are obtained.

Despite the paucity of material on the subject of the initial phase of treatment, a review of the literature reveals that there appear to be two basic schools of thought on the purpose and goals of the initial interviews:

1. A history is obtained by means of the therapist asking specific, structured questions; the patient is expected to provide the needed information which will enable the therapist to arrive at a clinical diagnosis.

2. The history is obtained in an unstructured way through the patient-therapist interaction; emphasis is on the establishment of rapport between the two and on the presenting problems and needs of the patient rather than on the mere gathering of information.

In 1954, Gill et al. published a substantial though brief chronological overview of the literature on initial interviews to that date. In that book they described how the earliest writers subscribed to the first school of thought, in that they believed that the purpose of the initial interview was to obtain a personal and family history and to evaluate the mental status of the patient.

This was influenced by Kraepelin and Meyer's theory of mental disorder based on the medical model which stated that the psychiatrist was first to study, then diagnose, and only then, to treat. Hence, the wide use of the highly structured question-and-answer early interview method which is utilized in certain settings even today.

In this same overview, Gill et al. stated that in the early psychiatric writings, emphasis was placed not on the patient-therapist relationship but on the techniques of the initial interview alone. For these early writers the initial interviews had four basic goals: "first, history taking; second, 'doing a mental status' . . .; third, formulating a diagnosis; and fourth, instituting treatment" (p. 19).

Gill et al. continued on to state that Henderson and Gillespie who wrote a textbook (1946) about "anamnesis" or history-taking and examination of the patient, said little about the methods of approach except that the psychiatrist should be aware of the fact that he is dealing with a person suffering from a mental disorder and the psychiatrist should therefore be "tactful, patient, and sympathetic." Nothing was said by these early writers about the patient-therapist rapport. The emphasis was rather on a complete and systematic examination to be conducted as soon as possible so that, as the patient

progresses, no part of the early material, however small, would go unrecorded (p. 21).

Despite this early emphasis on a rigid, formalistic approach to the initial interviews, an evolution away from this approach and toward a more flexible patient-centered interview began to emerge.

As early as 1917, Mary Richmond--the first social worker to formulate a theory which introduced social work as a profession with a specific body of knowledge--divided the beginning interview process into three phases of "study, diagnosis, and treatment."

Though in this early formulation, Richmond did not emphasize the need to consider the client's emotional state during the initial interviews, she did stress the need to put the client at ease to enable him or her to provide the needed information for the social study.

In 1942, social worker Annette Garrett described an unstructured method of obtaining necessary information. She said that the interviewer must obtain an understanding of three important factors; the problem, the situation, and an understanding of the client who is asking for help. Garrett cautioned that even though it is essential that the interviewer be clear of his purpose for the interview, the necessary information is "often best obtained by encouraging the client to talk freely of his problem rather than

by asking . . . pointed questions . . . ." Garrett elaborates further:

> People are sensitive about their personal life, family skeletons, poverty, past mistakes, and so on, and early flat-footed inquiry may only alienate a client and cause him to erect protective barriers against what may well seem to him unwarranted intrusion. Once convinced of the worker's sensitive understanding, of his desire to know not out of wanton curiosity but only in order to help, and of the confidential nature of the relationship, the client will welcome an opportunity to talk about things which earlier he would have suppressed (p. 26).

This heightened focus on the patient-therapist relationship significantly influenced the change of method away from the early Kraepelinian model of questions-and-answers.

The burgeoning influence of psychoanalysis, with its concepts of resistance, transference, and counter-transference was creating a heightened awareness of the importance of the patient-therapist relationship.

In 1948 psychiatrist Florence Powdermaker stressed the need to establish a therapeutic relationship in the initial interview. She stated that it is "only when the patient thinks of the doctor as a therapist rather than a gatherer of information does a real interchange of understanding and feeling develop" (p. 52).

Coleman (1949) elaborated further:

> The first requirements at the beginning of treatment . . . are: orientation of the patient in the process of treatment, clarification of the patient's feelings about treatment and about the therapist, and establishment of a treatment situation in which the balance between regressive and integrative trends in the patient may be maintained at a level most appropriate to the nature of his presenting problem (p. 189).

Coleman points out that in view of the above factors, the psychotherapeutic interview must be highly adaptive

> since it depends upon the nature of the precipitating problem, its relation to underlying personality needs and to the character structure, the extent of the patient's transference resistances and his tolerance of anxiety . . . . The psychiatrist sets up and controls the conditions of treatment, but he must also be extremely flexible in adapting these conditions to the requirements of his patient (p. 189).

Fromm-Reichmann (1950) also agreed that psychotherapy begins with the initial interview. The psychotherapeutic process, she stated "begins the moment the psychiatrist and prospective patient meet and establish a relationship for the purpose of determining the patient's difficulties and the means of alleviating them" (p. 69).

In 1952, in an article on psychotherapeutic techniques, Knight stated that "the outline for psychiatric examination . . . provides only the most elementary form for appraisal" of patients and should be disregarded when the psychiatrist gains experience. The rather awkward and

"compulsive sequence of the examination syllabus" is to be replaced by the "spontaneous unfolding of the patient's account of himself" (p. 116).

Gill et al. (1954) described this evolution away from rigid information gathering and toward the patient-therapist rapport as follows: "The emphasis changes from diagnosis to treatment, from information gathering to the fostering of an optimal therapeutic climate, from concern with the facts elicited to concern with the nature of the patient-therapist interaction" (p. 20).

They summarized that:

> The first departure from this psychiatric copy of medical schedules was due to psychiatrists' growing realization that history taking and mental examination cannot be divorced . . . forcing the patient's attention upon a set order of questions is unnecessary and distracting. The second important departure from medical tradition stems from the observation that the beginning of psychiatric treatment does not depend upon--not await--a careful formulation of the diagnosis. History taking, examination, treatment--all take place concomitantly, whether the examiner wills it so or not (p. 19).

In another statement that pointed out weakness in the formal question-answer model of history taking, Gill et al. agreed with Coleman (1947) who indicated that the formal method of obtaining a detailed personal and family history often directs attention away from the patient's stress and tensions experienced in his interpersonal relationships.

Gill et al. credited psychoanalysis as having the greatest impetus for change on the intervening methods. They stated that:

> The general impact of psychoanalysis has sensitized the ears of the average student . . . to the voice of the unconscious . . . . With the accent on understanding phenomena rather than on cataloguing them, an interview designed to understand and foster human relations could be expected. With the increasing knowledge of rapport, empathy, and particularly of transference and countertransference, the rigid question-and-answer schedule proved unsatisfactory (p. 27).

Social worker Perlman (1957) further discussed the nature of the worker-client relationship as it evolves in the beginning phase of treatment. She stated that through the caseworker's attitude of "attentiveness and receptivity" there evolves in the client an increased sense of safety in revealing his feelings and his problems. The client "begins to feel the burgeoning of relationship and the securing sense that, in feeling, the worker is with him." Perlman goes on to say:

> The relationship of trust and confidence grows not on acceptance and warmth alone. It depends for its sustenance on the demonstration that the caseworker not only wants to be helpful but knows how, and this becomes manifest in the ways the worker begins to help the client tell his troubles. He is not only an attentive listener; he is also an active inquirer (pp. 111-112).

In 1961 the Group for the Advancement of Psychiatry report stated that:

> The first consultative contact of a patient with a psychiatrist is an integral event within the total psychotherapeutic process . . . . Psychotherapy commences with the initial evaluative interviews (p. 437).

This Group disagreed with the authors who saw history-taking as a separate process from beginning treatment. The Group's report on the topic of the initial interviews unfolds in the following way:

> Certain aspects of the doctor-patient relationship may be influenced by the source and the method of referral even before the patient arrives at the initial interview . . . . Potential sources of misunderstanding between doctor and patient can often be avoided by a knowledge of those influences which preceded the interview itself . . . (p. 441).
>
> It is common knowledge that anxiety about a psychiatric interview and the implications of psychiatric treatment are ubiquitous. A large number of patients fail to keep their initial appointments at psychiatric clinics . . . . Embarrassment, shame and guilt are some of the . . . feelings that often accompany the patient's recognition that he needs psychiatric help . . . . Many apparently successful initial interviews, rich in information, have been followed by an unexplained disappearance of the patient whose anxiety about psychiatric treatment may not have been sufficiently recognized and alleviated during the interviews (pp. 442-443). [Italics mine]

The two British authors and caseworkers Ferard and Hunnybun (1962) agreed that the goal of the beginning casework process is to gain a "clear and factual account . . . of a client's problems and the circumstances of his life that have contributed to them." They believed that this account of the client's problem is best achieved by

allowing the interview "to develop in an unstructured way at first . . . [so that] the client is left free to discuss his feelings and thoughts without interruption, the asking of questions being left until later." This unstructured flow of the patient's thoughts provides the setting for the patient to feel heard and to "reveal other important aspects of himself though not immediately pertinent to his problem" (p. 38).

At first reading, Tarachow, a present-day psychiatrist and teacher who wrote a frequently referred to handbook of consulting-room techniques (1963), appears to subscribe to the early medical model in that he believes that the initial session should be used to obtain a detailed history by means of systematic goal-directed questioning. He further states that the patient should not have to decide if he wants to engage in treatment until after the first interview. Tarachow does, however, emphasize the significance of the patient-therapist relationship in that the therapist should be viewed by the patient as a helpful person who is able to understand his problems. "Friendliness," he cautions, on the part of the therapist "can be disastrous" and unfair in the first interview (p. 153). He continues to say that the "therapist has no right to disburb . . . [the patient's] defenses and provoke more anxiety or transference complications than a

tactful history-taking interview is going to create. If the patient returns for the second interview, . . . [the therapist then has] greater liberty" (p. 154).

Social worker Hollis (1964) views the first five or six interviews as a time to obtain in an unfolding way an extensive psychosocial study. During this critical period facts are gathered which will facilitate the formulation of a diagnosis and treatment plan. She points out, however, that "the fact-gathering process receives its impetus and direction from two sources: the client's desire to tell about his difficulties and the worker's desire to understand how they came about and what capacities exist for dealing with them" (p. 170). [Italics mine]

Hollis further emphasizes the importance of the client-worker relationship. She states the need for the client to have confidence in the worker as a helping person "so that he can speak fully and frankly" (p. 170).

In discussing the techniques of the social study process, Hollis says that the client should be encouraged to follow his own "threads of thought related to his problem as they come naturally to his mind . . . ." She indicates that by using sustaining interventions, the client will further develop his thoughts and the worker will gain adequate information. "At the same time the worker must fill the inevitable gaps . . . by directing the interview

along lines which the client does not spontaneously introduce" (p. 170).

Stevenson (1974) supports this unstructured interview approach. He says that although the modern psychiatric interview includes asking questions, the emphasis is now on a "free-flowing exchange between the psychiatrist and the patient" (p. 1137). For Stevenson, this modification in the initial interview approach is the result of "changes in the kinds of information wanted from patients and in . . . therapist's ideals of how best . . . [to] obtain this information" (p. 1138). He goes on to say that we first want to obtain from the patient what he wants to tell us which is usually a "description of his symptoms and the story of their onset and progress" (p. 1139).

In addition Stevenson states that the psychiatric interview, beyond being a mere gathering of information, "should provide the beginning of a trustful relationship in which psychiatrist and patient collaborate for the improvement of the patient's condition" (p. 1146).

Stevenson elaborates further:

> The psychiatrist should generally try to reduce or keep minimal the patient's anxiety toward him in initial interviews . . . . If the patient becomes very anxious with regard to the psychiatrist before a strong attachment has developed, he may block harmfully or fail to return (p. 1148).

Social workers Strickler and Bonnifil (1974) describe a three-fold purpose for the beginning phase of treatment. They say that it is a time "where the treatment goals are mutually agreed upon, the client is helped to work through his ambivalence toward the client role, and a working rapport with the caseworker is established" (p. 39).

Console et al. (1976) advocate the necessity of obtaining a "broad landscape of the patient's intra-psychic as well as external reality" in the first interview. This broad spectrum of information, they feel, is essential to making any kind of a "rational recommendation." They go on to say that:

> . . . if this knowledge is not obtained in a manner that inspires the patient's trust, hope and confidence, if an alliance has not been established by the end of the first meeting, then it will not really matter how much one knows about the patient. Because he may never return (p. 15).

The third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III)(1980), makes a full swing back to the early medical model of data-gathering via structured questions-and-answers. The manual states the following: "Planning a treatment program must begin with an accurate diagnostic assessment . . . . DSM-III reflects an increased commitment in our field to reliance on data as the basis for understanding mental disorders" (p. 1).

The manual goes on to advocate a "descriptive" approach to diagnosis. The etiology of the patient's disturbance is of little concern. "DSM-III diagnosis represents an initial step in a comprehensive evaluation lead- to the formulation of a treatment plan" (p. 9).

Although this manual is the most recently cited in this Review of the Literature, Part 2, the author feels that it does not, on balance, reflect the observable trend toward a more empathic and patient-centered approach to the initial interviews.

As we have seen in this section of the Review of the Literature, some authors, particularly the early ones (Kraepelin, Henderson and Gillespie), and most recently DSM-III, have argued that the initial psychiatric interview is for the purpose of beginning a diagnostic study in order to formulate a diagnosis. This procedure is based on the medical model of systematic data-gathering via questions-and-answers. These authors either ignored or were unaware of what was impacting emotionally upon the patient.

However, the preponderance of authors here cited are those who recognize the nature of the patient's needs and who address the emotional state as it is presented. These authors argue that a structured, data-collecting,

fact-finding interview leaves little room for consideration of the patient's true and immediate feelings.

Since their findings clearly support the concept that reduction of formalism in the initial interview modulates anxiety and decreases the risk of treatment failure, it is hoped that the reappearance of this structured, fact-finding model as found in the DSM-III manual does not reflect current prevailing trends or possible ones in the future.

Part 3
Narcissistic Vulnerability in Beginning Treatment

In this part of the Review of the Literature, two of the author's predominant contentions concerning narcissistic vulnerability in beginning treatment are explored:

1. The person coming for an initial interview is *per se* narcissistically vulnerable, i.e., in a state of lowered self-esteem, and it is this very state which precipitated him or her to seek professional help in the first place.

2. The fact that the patient must turn to a professional for help--and in so doing acknowledging his or her inability to deal with the problem--compounds the problem, threatening the already narcissistically vulnerable

person with the risk of further injury and loss of self-esteem.

These two issues are not necessarily separate. In fact, it is likely that in most cases of narcissistic vulnerability in beginning treatment, they overlap.

The contention that the person in the beginning phase of treatment is in a state of reduced self-esteem because of a problem he cannot solve himself is practically a given in the psychotherapeutic literature.

In her classical book on principles and methods of interviewing, social worker Annette Garrett (1942), conceptualized the client's dilemma in the following way: "Most people who come seeking help . . . are considerably troubled by their problem, as is evidenced by the fact that their anxieties have risen to such a pitch as to drive them to take the step of seeking this consultation" (p. 28).

Coleman (1949) stated that many patients cope with their anxieties and fear of treatment by masking their vulnerability:

> Most patients are at first fearful of treatment and fearful of the therapist and his reaction to them. They present many doubts about the ability of the therapist to help them, to understand them, to appreciate their problem, to respect them as people, and to be able to regard them with sympathy and without ridicule or rejection . . . . Often, however, attitudes of defiance, resentfulness, doubt and criticism toward the therapist represent a shallow facade intended to cover the patient's fears

> of rejection, his anxiousness about making a favorable impression, and his feelings that nobody can really be interested in wanting to help him (p. 192).

The need to seek the help of a professional is perceived as weakness in some sub-cultures of our society. The patient, therefore, is not only confronted with having to expose his weaknesses to a stranger who is perceived as superior and better off, but he may also be looked down upon by those individuals closest to him whom we would expect to comprise his usual basis of emotional support.

Social worker Hamilton (1951) addressed the question of external, socio-cultural factors that could raise the client's anxiety level and initial resistance to the therapy situation. She said that "a person may be ashamed to admit what seems to him to be failure to manage his own affairs, and his particular problem may also be culturally stigmatized . . . . Seeking therapy may be frowned on by the community . . . [in which he lives]" (p. 52).

Echoing Garrett and others, Perlman (1957) described the acute discomfort of the person who first comes for help. She stated that the person has a problem, a problem that is significant to the person because he has been unable to solve it himself. In spite of numerous attempts on the part of the client to cope with this problem, he has failed. Perlman went on to describe what the person's problem might look like:

> The nature of the problem might hold some particular fearfulness for him; it might spell for him the loss of his feeling of security . . . the loss of his sense of adequacy . . . or, worse, the loss of both. And the fears which the problem engenders begin to undermine the person further, to make him feel even more beset and helpless. So even a problem that is 'simple' on its objective face is complicated for the person who owns it, because it gnaws at him, drains his confidence and hope, and takes possession of him (p. 107).

In describing a person suffering from anxiety hysteria, social worker Austin (1957) demonstrated the global impact of this beginning treatment phase when she said: "In the initial contact, these clients show marked anxiety, ranging from an acute anxiety state to diffuse and pervasive anxiety feelings. The anxiety is accompanied by feelings of inadequacy and inferiority, of not being loved and appreciated" (p. 141).

Hollis (1964) brings our attention to this beginning discomfort and anxiety in social agency clients:

> It is well known that when a person must seek help from someone else, he undergoes discomfort and anxiety. Even when the assistance a client asks for is concrete and due him by right, he is uncertain whether the agency will recognize his eligibility. He finds himself in the humiliating position of having to ask even for recognition of his rights, dependent on the fairness of the worker in helping him establish these rights, and thrust into a situation in which he must answer questions about his financial, personal, and work life to the satisfaction of the interviewer (p. 83).

Hollis' concept of humiliation in an agency setting can easily be applied to a private practice or a mental

health clinic setting as well.

To paraphrase Wolberg (1967): Often patients enter therapy with feelings of shame at being unable to handle their problems themselves. They consider themselves to be weak and stupid.

Evidence of Wolberg's sensitivity to patients' feelings at this difficult phase of treatment is in his recognition that it takes an "act of courage" for the prospective patient to "swallow his pride" and to make the final decision to make that first appointment (p. 449).

Buie and Adler (1972) state that under these circumstances, the patient finds it devastating and humiliating when he experiences himself in comparison to the idealized therapist.

Throughout the literature, despite the fact that theorists described beginning treatment as a time of lowered self-esteem, the actual terms narcissistic vulnerability and narcissistic injury in relation to the beginning phase of treatment were not generally used until the emergence of Kohut and the other self psychologists.

In 1980, lecturing on narcissism as resistance to the initial phase of treatment, Kohut observed that most analysts recognize this as general "non-specific resistance" against treatment as a whole. He emphasized that Wilhelm Reich (1933-1934), who wrote of "narcissistic

resistance as character armor" and who maintained that "it was the task of the analyst to penetrate this narcissistic armor," left his lasting "mark on analytic practice, even today." Kohut takes issue, however, with Reich's concept of the need to "pierce the narcissistic crust" of the patient. Kohut maintains that at this delicate early phase of treatment it is the therapist's aim to "help the patient understand the significance of his narcissistic reactions" (p. 553).

In "Negative Expectations of Treatment" (1973), social worker Powel writes of the positive therapeutic alliance that is possible between client and therapist but cautions that in its early stages before this alliance has had time to form, "treatment may set in motion certain regressive forces." Because the "prospect of treatment focuses the client's attention on his own short-comings, the tendency to dwell on his inadequacies is likely to be intensified. It is not until the therapeutic alliance is formed that the extreme sense of vulnerability can be somehow relieved."

Arnold Goldberg, self psychologist and colleague of Kohut, states (1975) that "the beginning of treatment for almost every patient is characterized by exposure of their imperfections and submission to someone who is perceived as better off" and that since the issue of low self-esteem is

a factor in every psychotherapy it is imperative that it be addressed early in treatment. He points out that in some cases self-esteem regulation is the primary focus, in other cases it is of minimal importance but "never is it insignificant." He goes on to say that "sometimes minor but often quite severe feelings of shame and humiliation accompany most treatment starts . . ." and in fact a variety of "so-called precipitating events" seem to be "one or another form of hurt feelings, damaged self-esteem, or wounded narcissism" (p. 696).

Further evidence of the patient's state of lowered self-esteem in beginning treatment can be drawn from the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (1980). Practically every diagnostic category in this manual has descriptive criteria that are generally recognized by clinicians as symptomatic of lowered self-esteem. Such descriptive criteria as "impairment in social or occupational functioning . . . deterioration from a previous level of functioning in such areas as work, social relations, and self-care, . . . social and marital impairment" all are recognized as symptoms of low self-esteem or as factors that could contribute to a reduction in self-esteem.

Whether self-esteem is defined in the classical way, as ". . . a state of being on good terms with one's superego" (Hinsie and Campbell, 1977, p. 690), or in a self psychological way--"the capacity to feel joy, pride and enthusiasm about one's goals and ambitions . . . that permits the actualization of one's potential . . ." (Palombo, 1979c), it is evident from this review of the literature that in the beginning phase of treatment the problems that bring a person to the therapist's office and the process of beginning to work on these problems can contribute to a diminished state of that self-esteem and ensuing susceptibility to narcissistic injury.

CHAPTER IV

THEORETICAL FRAME OF REFERENCE: SELF PSYCHOLOGY

Kohut's psychology of the self has provided therapists with a theory that offers a new dimension with which to understand how the patients in beginning treatment might be impacted by the phenomena of lowered self-esteem and the ensuing narcissistic vulnerability.

This chapter will provide an overview of the constituents of Kohut's theory that are applicable to the understanding of these phenomena. Although it is the author's premise that lowered self-esteem can be recognized descriptively, that is by the manifest symptoms, and that the psychodynamic reason for the patient's narcissistic vulnerability is not the crucial issue in beginning treatment, the case material presented in Chapter V will be analyzed using self psychology as a theoretical frame of reference.

As the term, psychology of the self, appropriately implies, Kohut's theory is a psychology of the self, not a psychology of the ego or the id or of the drives. The predominant focus is on the development of a cohesive self

rather than on the development of a functional or organizing ego or the resolution of the oedipus conflict.

Kohut states that a person who successfully develops a mature, autonomous, cohesive self is one who has the capacity for humor, empathy, creativity in line with one's talents and skills, wisdom and the capacity to contemplate one's own death.

The Development of a Mature Cohesive Self

Kohut defines the self as the core of the personality which develops from birth onwards in response to the interplay between the child's narcissistic needs and the important people in his environment--usually the parents or other primary caretakers. These important people are called selfobjects because they are experienced by the child as a part of the self. The selfobject performs for the child certain needed psychic functions that he is not yet able to provide for himself. It is not the mother or father *per se* that the child invests his energy in, nor is it the mental images of them, but the functions of the selfobjects that the child invests. In other words, the child invests his energy in the functions or the way that the selfobjects respond to his narcissistic needs. Kohut (1972) states that the selfobject experiences of childhood become the model

for the nature of the adult's security or vulnerability in the narcissistic realm of his personality:

> The ups and downs in our self-esteem; . . . our lesser or greater need for praise, for merger into idealized figures, and for other forms of narcissistic sustenance; and the greater or lesser cohesion of our self during periods of transition . . . are determined by our early selfobject experiences (p. 369).

Kohut has divided the narcissistic needs into two major categories which are derived out of the child's age appropriate requirements. The following is an example of these early needs.

If we think of a young infant who at first is unable to differentiate between himself and mother and is in fact in a merged state of symbiosis--a blissful and omnipotent state for the infant in which he feels that everything revolves around him--his every need is met. If he is hungry he is fed; if he is sleepy he sleeps. He is admired, loved and gratified by the parents. The infant at this stage possesses an archaic or underdeveloped self.

As the child grows and differentiates from mother he is confronted with the reality that there is a big world over which he has no control. There are numerous frustrations and he feels vulnerable. In order to maintain some semblance of inner security and equilibrium, the child more than ever needs the parents as selfobjects to protect him

against the loss of his own omnipotence. The parental self-objects are called upon to perform two basic functions for the child, the "mirroring" function and the "idealizing" function. If the parental selfobjects are reasonably empathic with the child's needs the child will gradually take in and develop the ability to perform these functions for himself.

The first selfobject function leads to the maturation of the grandiose self. The selfobject needs to continue to admire the child in order to confirm or "mirror" his greatness. The selfobject is called upon to "mirror" or reflect back the child's early grandiose feelings--feelings of being wonderful and "the center of the universe" (Palombo, 1976, p. 151). To the degree that the selfobject appropriately affirms the child's grandiose needs, the child will carry into adulthood a sense of self-esteem, self-confidence and the capacity to experience joy and pride in his own achievements. This capacity to affirm his own grandiose needs is acquired by the gradual internalization of the functions of the "mirroring" selfobjects--a process that Kohut calls <u>transmuting internalization</u>. This line of self development is called the line of the "grandiose self."

Kohut (1968) states that the internalized grandiose self in the adult personality supplies the fuel for one's healthy ambitions, for the enjoyment of one's activities,

and for important aspects of one's self-esteem (p. 87). Kohut further states that to the degree that this adult suffered from severe narcissistic trauma in childhood, his grandiose self will remain in its immature form and will continue to strive for the fulfillment of its archaic aims, i.e., the adult will seek out admiration and reassurance from other adults who are experienced as selfobjects. Without these selfobject ties the adult will lack a sense of narcissistic equilibrium.

The second selfobject is known as the "idealized parent imago" which has two sub-functions: one is a protective function and the other is the soothing function. These functions are in response to the child's need to have a selfobject whom he can look up to--to see as omnipotent. Since the child has been confronted with the loss of his own omnipotence, he needs to merge with an omnipotent selfobject during times of tension and anxiety. The idealized parent imago soothes, calms, and modulates the child, providing him with feelings of being protected from a potentially overwhelming and overstimulating world.

Kohut (1968) states that the internalized idealized parent imago is evidenced by the adult who experiences pleasure in obeying the dictates of his conscience as well as in living up to the "guiding leadership of its ideals" (p. 87).

The adult with a cohesive idealized parent imago is able to admire others for who and/or what they are while having the capacity to be enthusiastic about his own achievements. To the degree that the child experienced traumatic disappointments in the admired adult, he will enter adulthood with a limited capacity for tension-regulation and he will require other adults as selfobjects for the maintenance of his narcissistic homeostasis (Kohut, 1968, p. 87).

Under optimum developmental conditions, the child, through the process of transmuting internalization, is able to internalize the functions of the selfobjects into a mature cohesive autonomous self--a self that is not easily susceptible to narcissistic disequilibrium and fragmentation. However, the greater the deficit in the cohesive self--the more susceptible and vulernable the self is to narcissistic injury.

Under normal conditions, the adult with a mature self enjoys individuals as separate entities rather than as selfobjects or as a part of the self. It is important not to take this separateness too literally. Eisenhuth (1979), in an overview of Kohut's theory, writes about the existence of "selfobject relations on all developmental levels, . . . in psychological health as well as in illness. In all mature love relationships, the love object is also a self-object, and there is mutual mirroring and idealization

which enhance self-esteem" (p. 51).

Palombo (1980b) clarifies that it is the degree or intensity of the selfobject attachment that determines the pathology. Kohut (1980) further addresses the prevailing role of selfobject relations. He writes that ". . . man lives in a matrix of selfobjects from birth to death. He needs selfobjects for his psychological survival, just as he needs oxygen in his environment throughout his life for physiological survival" (p. 478). Kohut further elaborates that the person who has "failed to reach his aims or to live up to his ideals . . . will suffer from lowered self-esteem, but if his selfobjects are intact . . . even conflict, failure, and defeat will not destroy his self, however great his suffering may be" (p. 479).

Kohut views the self described above as a bipolar self. The bifurcate line of self development forms two poles--the grandiose self and the idealized parent imago. The grandiose self line develops the ultimate capacity for ambitions, self-assertiveness, and self-esteem and the idealized parent imago line is the basis for ideals promoting the capacity to regulate inner tension. There is a third constituent of the bipolar self which is thought of as a tension arc which establishes itself between the two poles. The inevitable tension between the person's ambitions (grandiose self pole) and ideals (idealized parent

imago pole) activates the innate talents and skills and puts "them into action to fulfill the intrinsic patterns for creative expression laid down in the structure of the bi-polar self" (Ornstein, 1980, p. 143).

Palombo (1979c) states that the archaic self matures into a nuclear self at about the age of 2 or 2-1/2. This is the first consolidation or cohesion of the self and is called the nuclear self. The nuclear self arises out of the interaction between the infant's innate talents or limitations and the selective experiences with the grandiose self and the idealized parent imago. Kohut and Wolf (1978) write that these selective selfobject experiences arise out of the "hopes, dreams and expectations concerning the future child in the minds of the parents, especially the mother" (p. 416).

Kohut (1977) states that the child has two chances as he moves toward a consolidation of the self. If the child's grandiose self needs met with empathic failure from the mirroring selfobject, the development of a cohesive nuclear self will suffer. The child, however, has a second chance at cohesion with the idealized parent imago. "Self disturbances of pathological degree result only from the failure of both . . ." the grandiose self and the idealized parent imago (p. 185).

Kohut and Wolf (1978) view disturbances of the self as either primary or secondary. The person with primary

disturbances of the self suffer from self deficiencies of pathological proportions which are based on the intensity and the urgency of the selfobject need. The nuclear self may be non-cohesive, as in psychosis, or it may have suffered only temporary "break-up, enfeeblement or serious distortion of the self" (p. 416).

A person who suffers from a primary disturbance of the self is exceedingly fearful of the dejection that follows an unsuccessful venture and/or fearful of the grandiose fantasies that follow success and which are not modulated by the person's idealized parent imago.

Conversely, a person who has a secondary disturbance of the self has a fairly well functioning cohesive self but because of a loss or an unusually stressful situation the person's narcissistic equilibrium is temporarily knocked off balance. This person, Kohut and Wolf (1978) say, would be able to "tolerate wide swings of self-esteem in response to victory or defeat, success or failure" (p. 414).

Kohut and Wolf (1978) profess that the nature of the parents' nuclear self is more important in the child's self development than is the parents' philosophy of life. To that end Kohut states that "it is not so much what the parents <u>do</u> that will influence the character of the child's self, but what the parents <u>are</u>" (p. 417). This statement

also directs the focus of the problem away from a single trauma in life. It is the chronic attitude of the self-objects--their almost persistent failure to provide the needed selfobject functions based on the child's needs--that cause the weakness in the self. The occasional unavoidable failure on the part of the selfobject does not cause a deficit in the self structure. In fact, it is partly through these occasional failures that the child gradually builds his own self structure.

Introspection and Empathy in Treatment

In 1957 Kohut wrote about empathic introspection as a tool for psychological observation. What he means is that in order for therapists to understand what their patients are feeling, they must introspectively merge with them while maintaining cognitive awareness of the merger. Kohut (1957) gives an excellent example of introspection and empathy when he states that:

> We see a person who is unusually tall. It is not to be disputed that this person's unusual size is an important fact for our psychological assessment--without introspection and empathy, however, his size remains simply a physical attribute. Only when we think ourselves into his place, only when we, by vicarious introspection, begin to feel his unusual size as if it were our own and thus revive inner experiences in which we had been unusual or conspicuous, only then can we begin to have an appreciation of the meaning that the unusual size may have for this person and--only then have we observed a psychological fact (p. 461).

Through the use of introspection and empathy we offer the patient a second chance at transmuting internalization of the needed selfobject functions.

In treatment then, our task is to understand what difficulties the patient is having in response to deficits or weaknesses in the cohesive self. We do this by understanding the patient through the selfobject transference, via introspection and empathy. Just as the person who had less than optimum selfobject experiences in childhood will continue to seek selfobjects as an adult, he will also form a selfobject relationship with the therapist if he is not blocked by premature interpretations or the therapist's own discomforts in being idealized or used as a needed selfobject.

CHAPTER V

CASE VIGNETTES

This chapter consists of six case vignettes that were selectively extracted from the author's clinical experience for the purpose of illustrating her theoretical beliefs and enriching the study.

Each vignette focuses on significant material that shows evidence of the patient's narcissistic vulnerability. The theoretical discussion is viewed from a self psychological point of view focusing on the patient's self vulnerabilities.

The first three case examples were seen in the author's private practice and the second three were seen at a public mental health clinic.

Each of the six case presentations is followed by a discussion of those factors in beginning treatment that appear to be associated with the patient's heightened state of narcissistic vulnerability. These factors are divided into two major categories: (1) the patient's intrapsychic factors and (2) the extrapersonal factors.

Intrapsychic factors are twofold. First are the reasons that precipitated the person's decision to begin treatment and second is the impact of the initial

therapeutic experience on the patient. An example of the former situation is that most people come to therapy as the result of some kind of life crisis which causes them to experience lowered self-esteem or wounded narcissism. The person may generally suffer from low self-esteem but something occurred that made the feelings more acute.

The latter is exemplified by the often devastating injury to the person's narcissism when he is confronted with his inability to deal with his problems himself.

Extrapersonal factors are those injuries that occur as a result of the setting, ancillary staff or the therapist who has been required to follow clinic procedures. These external factors inadvertently inflict narcissistic injuries onto the patient. Although these narcissistic injuries may occur in private practice as well as in the clinic, they appear to be more prevalent in the clinic setting.

The Case of Mrs. A

Mrs. A was a 25 year old, married woman who was seen in the author's (hereafter referred to as the therapist) private practice. She worked full-time as a dental assistant and she lived in her own apartment until she married her husband.

When Mrs. A first called to arrange for an appointment, the therapist was not immediately available so Mrs. A

left her name and telephone number for the therapist to return her call. The therapist returned the call about two hours later. Mrs. A reported that she had obtained her name from a friend's therapist and that she would like to arrange for an appointment if the therapist had time available in the evening. Mrs. A spoke very fast and to the point. (The therapist speculated that Mrs. A must have called very shortly after obtaining her name because the therapist had spoken to the referring colleague that same afternoon and no mention of the referral had been made. It appeared that this was an indication of a fairly anxious woman.)

Because of Mrs. A's seemingly high level of anxiety, an appointment was made for the earliest possible time which was the following Monday.

Mrs. A, a neatly dressed, slender, red-haired woman, arrived at her first appointment promptly. She appeared to be rushed and rather windblown even though it was not a windy day. The therapist recognized Mrs. A as a woman that she had seen frantically running up the street toward her office building as the therapist herself was arriving well ahead of the assigned appointment time. Upon meeting Mrs. A in the waiting room, the therapist introduced herself and invited Mrs. A into the office. Mrs. A entered and hesitantly looked at all the chairs--waiting for the therapist to tell her where to sit. The therapist complied by

gesturing with her hand. Mrs. A seemed to be rather shaky--not in a trembling way but her motions were fast and jerky. She had difficulty making eye contact.

The instant that Mrs. A sat down she began to talk. It seemed as though she was aware that she was expected to tell her story about why she decided to come to therapy but her speaking was also jerky--she made sudden starts and stops--first looking at the therapist and then moving her eyes away. In this fashion, she told the therapist that she didn't know what to say--that she needed to be asked some questions. The therapist responded in a manner that conveyed acceptance and empathy that Mrs. A seemed to be "pretty nervous." Mrs. A said that she was always nervous when she had to talk to someone in a doctor-patient role. The therapist replied that it is indeed difficult for most people to walk into a stranger's office and just start talking about their problems. The therapist, recognizing that Mrs. A needed some structure to help ease her anxiety, took an active stance and inquired as to whether Mrs. A had ever been to see a therapist before.

In a somewhat cautious and apologetic way, Mrs. A said that a few months ago she had seen another therapist at a clinic and it was a terrible experience. She said that at the end of the first session the therapist informed her that she would have to be seen in group therapy. Mrs. A

said that she felt that the therapist didn't even try to help her express herself and so she decided not to return. Mrs. A reported this in a rather embarrassed way, conveying the feeling that she feared that this therapist might be critical of her actions.

Mrs. A had given a number of clues as to what her areas of vulnerability might be and the therapist kept these uppermost in her mind as the session proceeded.

Mrs. A went on to say that she came to therapy because she had been "very anxious, crying a lot, and basically unhappy." The problem had existed for some time and even though she left the other therapist with feelings of great dissatisfaction, she decided that she could not stand her discomfort any longer, so she decided to try again.

Mrs. A said that her father and adoptive mother were supportive of her decision to seek therapy as was her husband. She said that her adoptive mother told her that she complained too much and that whenever Mrs. A tried to talk to her adoptive mother about her feelings, the reply would be, "Don't worry" as if to "shut her up." Recently, Mrs. A's best girlfriend also had been cutting her short by saying, "Don't worry."

As Mrs. A's history unfolded through the next few sessions, the therapist learned that Mrs. A's mother had died when she was three years old and that she was sent to

live with her paternal aunt until her father remarried, about two years later. Mrs. A had no memory of her mother. Further, she felt that she was not given an age-appropriate explanation for her mother's death nor did she understand why she was sent to live with her aunt while her brother remained with the father. Although Mrs. A grew to love her aunt, after returning to her father, she remembered crying whenever she would go to visit her aunt. She was afraid that she would be left again.

Mrs. A said that even today she dislikes losses and changes. Also, she tends to keep jobs for long periods of time even after she becomes dissatisfied and it is difficult for her to move from one apartment to the next.

Mrs. A said that when she became 19 years old her parents decided to sell their house and move into an apartment. They decided that she should move out on her own. Mrs. A did not feel that she was prepared for this sudden emancipation because she had always been over-protected by her adoptive mother.

For several sessions, Mrs. A needed help in getting started but as she become more comfortable she was able to begin the session by herself.

Discussion of Mrs. A

Intrapsychic Factors

Mrs. A's level of anxiety, as evidenced by her rapid speech, her rushed and windblown appearance, her fast and jerky motions, and her difficulty in making eye contact, suggested that she was unsure of herself and fearful of the outcome of the session.

Because of Mrs. A's presenting problem--her crying and general unhappiness--and the non-empathic responses from significant people in her life, it is understandable that she would come to treatment with fears that the therapist might also have an unfavorable impression of her. This fear was compounded because of the "terrible" experience that she had with the first therapist. Because of these selfobject failures, Mrs. A was looking to the therapist to provide the needed selfobject functions to help her to reestablish her narcissistic equilibrium.

Although Mrs. A came from what she called a large and close family, it seemed evident that she not only experienced the ultimate loss of a selfobject--the death of her mother at age three--but also she experienced chronic empathic failures by her father and adoptive mother's lack of understanding and empathy of her selfobject needs.

As a result of these selfobject failures and the subsequent weaknesses in her mature self, Mrs. A suffered

from a basic sense of low self-esteem. She needed approval and acceptance--indicative of a weakness in her grandiose self--but she also needed to merge with an idealized parent imago in order to calm herself.

This latter point was evidenced by Mrs. A's reason for coming to therapy. She said that she had been "anxious, crying a lot and unhappy." She also reported that her mother said that she was "complaining too much."

Mrs. A's complaining and overall dissatisfied feelings were the outcome of her vulnerable self. Her narcissistic equilibrium was in a "wobbly" state because her self-objects were failing to provide the soothing and calming functions that she required. Although Mrs. A's marriage appeared to be quite stable, her husband was not the kind of person to provide the idealized selfobject functions for Mrs. A. In fact he was described as a rather quiet though at times abrasive individual who seemed to further upset her narcissistic equilibrium because he would not be concerned if he offended other people, not even Mrs. A's family.

Mrs. A had a pervasive though underlying fear that she would lose her job, her husband would fail at his business, and she would be "out in the cold" in an unprotected environment--just as she was at age 19 and before that at age three when her mother died.

Mrs. A turned to the therapist as a selfobject to guide her along, to help her express herself, not so much because she did not know what to say but because she would regain her sense of self if she could merge with the therapist as a protective and calming selfobject. She feared, however, that if the therapist failed to be empathic with her needs, that she might experience a fragmentation--that is, that her anxiety would be so great that she would not be able to cope with her feelings.

During the first hours of therapy, had the therapist maintained a passive, non-directive stance with Mrs. A, or even worse, had the therapist interpreted Mrs. A's behavior, Mrs. A might have suffered another serious narcissistic injury and probable treatment failure. By the therapist's appropriate, timely interventions, i.e., her empathic responses to Mrs. A's fears about the patient-therapist relationship, her gentle guiding stance to help Mrs. A unravel her story, and her willingness to refrain from making interpretations, a selfobject tie was established and Mrs. A's anxiety greatly diminished, enabling her to verbalize her feelings more freely.

Extrapersonal Factors

Although the patient's intrapsychic vulnerabilities are important in the beginning treatment situation, it is of paramount importance to determine whether the patient

is presently suffering from narcissistic injuries. Injuries inflicted by the therapist or any aspect of the treatment situation are first in importance.

The therapist suspected that Mrs. A's extreme degree of anxiety, which did not seem to be consistent with her overall personality (she manifested no signs of a thought disorder or mania, and she held a full-time job), was directly related to the therapist as representative of the treatment process as a whole. Since Mrs. A entered the office in this anxiety state, the therapist assumed that she personally had done nothing to cause Mrs. A injury. The most obvious direction to explore was Mrs. A's previous experience in therapy. This indeed was an immediate source of her anxiety.

Because the first therapist inflicted narcissistic injuries which caused Mrs. A to drop out of treatment after the first session, Mrs. A transfered similar expectations to the second therapist and the new treatment situation.

The therapist's guess, based on her general knowledge of clinic procedures, is that Mrs. A fell victim to a clinic procedure. The first therapist must have known that she did not have an individual hour available in her schedule to see Mrs. A but in spite of that she was required to see her for an initial interview and then to refer her to a group for ongoing therapy. Whatever the details might have been, the

referral was not appropriately handled by the therapist. This was bared by the fact that Mrs. A felt that the interview was a "terrible" experience and she did not return to the therapist or the clinic a second time. Mrs. A had suffered a narcissistic injury and had therefore joined the ranks of early dropouts.

Fortunately, Mrs. A was not so vulnerable that she would not allow herself to risk another therapist. Indeed, she learned from her experience of blindly going to a clinic and this second time she obtained the name of a therapist from a friend and she clarified with the therapist on the telephone ahead of time whether the therapist had time to see her in treatment.

The Case of Miss B

Miss B, a 26 year old Caucasian, Protestant woman, was referred to the therapist's private practice. She was a second year doctoral student, majoring in Slavic languages and she worked part-time as a clerk in a department store. Miss B lived alone in her own apartment. She grew up in the East where her parents and two siblings still live.

When Miss B telephoned for her first appointment, she explained that she had been referred by a good friend of hers who was a former patient of the therapist. Miss B gave the therapist no indication of her problem other than

that she felt she could benefit from talking with someone. The call was brief and to the point. Miss B sounded pleasant and in control of herself on the telephone. Her voice sounded calm and her speech was moderate.

The therapist was able to arrange an appointment with Miss B for the following day. Questions were answered about the fee and the telephone conversation ended with the therapist providing Miss B with the needed instructions on how to find the therapist's office.

Miss B arrived promptly for her scheduled appointment. The therapist observed that she was an attractive, neatly groomed and conservatively dressed young woman. Upon meeting she extended her hand and the therapist responded in kind. Miss B sat in the chair opposite the therapist in a somewhat erect though not stiff manner. Her facial expression was relaxed and bright though serious.

Miss B began by taking a deep breath and stating that she had been talking to her friend about problems that she was having with her boyfriend and that her friend, whom she highly respected, suggested that she should see a counselor. He suggested the therapist because he felt that Miss B would feel comfortable with her.

Miss B said that she was considering breaking up with her boyfriend and that she was painfully aware that she had not been able to sustain a relationship with a man

for more than three months. She said that she would eventually like to marry and have children but that she feared that she never would.

The therapist listened to Miss B who focused on her feelings about her presenting problem. When it seemed timely, the therapist directed the emphasis to her previous relationships and to information about her personal and family history and her present personal situation.

Miss B said she dreaded telling her parents that she was seeing a counselor because they emphatically believed that she should be able to solve her problems by herself. This is an attitude which has to do with self-reliance and family pride. In this family if personal problems do arise it is to family members that you must turn for help. Miss B, however, expressed ambivalence about this family dictum. She said that when she gets upset her mother also gets upset, thus compounding her problem by adding feelings of guilt for disturbing her mother to an already unsettling situation.

Miss B's father, on the other hand, was described as a person who did not listen to her feelings. His only interest "is on achievement and he is critical of anything that falls short of perfection."

By the end of the session the therapist was beginning to formulate a picture of how fearful Miss B was of asking for help. The therapist tucked that away in her

memory bank but made no mention of the appraisal at that time.

The session ended by summarizing what had been identified as the problem and how Miss B's familial attitudes impact her problem. For the most part, this was a supportive session in which the therapist listened to Miss B's feelings about her coming to a "counselor," and many of the therapist's interventions were subtly geared toward giving Miss B permission to turn to someone outside of her family for help.

Early in the second session Miss B expressed how difficult it had been for her to make the initial appointment with the therapist. Although she had seen a counselor for a brief time during another crisis in her life and the experience was a positive one, she somehow felt that turning for help again indicated a real sign of weakness.

Miss B said that with much reservation she had told her mother about her decision to see a "counselor." She said that her mother tried to understand her decision but that her mother's usual overconcern came through when she subsequently telephoned her on three consecutive days to inquire about "how she was doing." Miss B indicated that she was not prepared to tell her father of her decision though she suspected that her mother would tell him.

This session focused predominantly on Miss B's feelings about needing help. It was clear that she wanted help

but that needing help was also a narcissistic injury.

Discussion of Miss B

Intrapsychic Factors

Miss B did not outwardly exhibit signs of anxiety. Her apparent calmness on the telephone, the extension of her hand upon meeting the therapist and her erect posture gave her an appearance of calm self-confidence. The deep breath as she began to speak, however, was a clue that perhaps her inner feelings were not as calm as her outward demeanor might suggest.

This empathic observation was verified by Miss B in the second session when she told the therapist how difficult it had been for her to make the initial appointment. She said that turning for help was a sign of weakness that she did not want to face.

Miss B obviously had integrated her familial attitudes about the need to be in full control of herself. It was a narcissistic injury for Miss B to show her weakness to her parents and to the therapist. Miss B attempted to soften the injury to her self-esteem by referring to therapy as "counseling" in spite of the therapist's use of the former term. This interpretation was verified much later in the treatment after the therapeutic relationship was firmly established. Miss B revealed that her use of the term

"counseling" was not as threatening to her--that to need therapy meant that she really had a problem.

One of the early goals in treatment was to enable Miss B to remain in treatment. This was accomplished by consistently dealing with her narcissistic injury in response to her need for help.

Miss B developed an idealized relationship with the therapist. When Miss B would experience undue stress or feelings of depression, she would turn to the therapist for strength and comfort. Miss B possessed a weakness in her inner capacity to calm and soothe herself because her mother, who responded to Miss B's narcissistic injuries as though they were her own, had not adequately provided for Miss B in childhood the needed selfobject functions. Therefore, Miss B did not have the opportunity in childhood to internalize these functions of an idealized parent imago.

As frequently is the case, Miss B also manifested a secondary vulnerability in her grandiose self. She was persistently trying to please her father so that she could prove to him that she was the wished-for perfect child whom he could be proud of. In her early years Miss B's "mirroring" attention had not been given for the purpose of helping her to develop an independent and vigorous self. Rather, she was treated like a puppet who could be manipulated into

postures and behaviors which would help to fulfill her parents' grandiose self needs.

Extrapersonal Factors

Although Miss B had internalized her parents' values, i.e., turning to therapy for help demonstrated unacceptable weakness, their disapproval of her decision to be in treatment can also be viewed as an extrapersonal factor.

The nature of Miss B's referral--that she was referred by a friend that she both trusted and respected--gave her the initial strength to come to treatment just as conversely many people might not make the decision to engage in treatment because of influence from family, friends or certain socio-cultural factors.

In Miss B's case, her friend was someone whom she highly respected--he was an idealized parent imago for her. By merging with the security of his ideals--that going to therapy is a worthy action--Miss B was able to go against her parents' ideals and expectations. Soon the therapist was to provide that idealized function for her.

The Case of Miss C

Miss C, a 19 year old Caucasian, divorced woman, was referred to the therapist's private practice by a colleague who had seen Miss C one time for the purpose of evaluation and referral. The colleague was unable to work with Miss C

on an ongoing basis because Miss C's cousin's wife was already in treatment with her.

When Miss C telephoned and explained that she had had one consultation with another clinician, the therapist acknowledged that she had spoken to the referring clinician and that she was aware of the nature of the referral. An appointment was arranged for the following week.

Miss C arrived early for her first appointment. The therapist could hear her in the waiting room frequently clearing her throat in what seemed to be a nervous fashion. At the assigned time, the therapist greeted Miss C and invited her into the office.

Miss C, though she wore a fixed smile, looked older than her 19 years of age. She was dressed casually in loose fitting clothes--blue jeans, sandals, a smock-type blouse and no bra. She had long, straight hair which frequently covered half of her face.

Miss C sat on the sofa opposite the therapist, first sitting in a slumped position but soon putting her feet up on the sofa in almost a reclining position. (The therapist viewed this seemingly over-relaxed posture as indicative of the opposite--she was quite tense and anxious.)

From the moment that the therapist met Miss C in the waiting room, Miss C had a smile on her face--not one that would be perceived as a pleasant smile but a smile that

perhaps covered feelings of self-consciousness or discomfort.

Miss C began the session by increasing her "smile" to a point that her mouth was wide open and she exclaimed with considerable embarrassment, "Wow, I'm here but I don't know what to say!" The therapist responded by suggesting that perhaps she would like to begin by sharing why she decided to see a therapist.

Miss C said that she came to treatment in an effort to "get her head on straight." She was fairly spontaneous in detailing her present life circumstances and her past history. At the age of 16 Miss C had dropped out of high school and married--living in close proximity to her parents. The marriage lasted only two years. Following the divorce, Miss C moved back into her parents' home where she lived until she "ran away" and came to Los Angeles.

Miss C said that she had done everything in her life to gain acceptance by her mother at the expense of gaining her own identity and that she couldn't do anything right for her mother.

Her father, whom she said that she loved and with whom she enjoyed a fairly good relationship, was nonetheless overpowering and domineering. Miss C described him as a "businessman, and playboy, who would go off to conventions in Las Vegas and have affairs." Miss C said that she knew

about the affairs because lately her father was very open about these activities and did not make any effort to conceal from her his sexual liaisons. This development in the father-daughter relationship was particularly distressing to Miss C because she had always tried to idealize her father and this was making that difficult.

In contrast to her "bon-vivant" father, Miss C's mother was described as a depressed, self-consumed woman who constantly "nagged" for attention from husband and daughter alike and who constantly worried about "what other people would think." An example follows:

Miss C recalled an incident when she was in high school. She had been participating in a physical education activity when she suddenly became very upset, severely anxious and apparently confused. Subsequently, Miss C's mother was summoned to the school to take her daughter home. When the mother arrived at the nurse's office where Miss C was lying down, she said to Miss C, in a furious and rageful manner, "Why are you doing this to me?"

Needless to say, at this moment, Miss C keenly felt the absence of a caring, protective (selfobject) mother.

As Miss C described this painful incident her smile lessened and her affect became more appropriate to the content that was unfolding.

Near the end of the first hour, Miss C commented that twice during the session she had been aware of wanting to "hold back" information. Once was when she had mentioned meeting a young man at a bar and subsequently going to bed with him that same night. She said that she was fearful that the therapist would not be accepting of her behavior. The second incident that made her feel uncomfortable was when the therapist looked at the clock. It made her feel as though the therapist wanted the hour to end.

(This latter issue was consistently dealt with during the treatment. The therapist learned through the months and years to come that Miss C felt exceedingly uncomfortable with beginnings and endings of sessions. She said that she cleared her throat in the waiting room to let the therapist know that she was there, with hopes that the therapist would care enough about her to start the session early. Further, the end of every hour felt to Miss C like a rejection.)

At the conclusion of the first hour, Miss C confessed that she was less afraid but that she felt more comfortable with the other consulting clinician. The therapist responded to this sensitive statement in a way that seemed to be empathic with Miss C's most conscious feelings.

In light of Miss C's narcissistic vulnerability, her need to be thought well of and her fears of rejection, the

therapist realized that it would probably be easier for Miss C to feel comfortable with a therapist whom she would not have to risk forming a relationship, i.e., someone with whom she would not continue in treatment. However, recognizing that such an interpretation would be premature in a first session, the therapist responded in a way that was more empathic with Miss C's conscious feeling level. She commented that Miss C really had her heart set on seeing the other therapist and that she could understand her disappointment.

Discussion of Miss C

Intrapsychic Factors

Miss C is an example of a young woman who came to treatment as the result of a life crisis but who obviously suffered from multiple lacunae in both lines of her self development--her grandiose self and her idealized parent imago.

This is understandable given her mother's apparent narcissistic weaknesses: (1) her apparent inability to provide Miss C with affirmation of her grandiose needs--to feel special, loved and admired; and (2) her apparent inability to provide soothing, calming and modulating functions.

Furthermore, Miss C's father telling her about his sexual affairs, rendered himself an inadequate idealized parent imago for Miss C.

Lacking these internalized selfobject functions, Miss C felt overwhelmed by her anxiety. She had moved from her small midwestern home town to the vast metropolis of Los Angeles. Being in this strange city, maintaining her first full-time job, and living alone in her own apartment without her parents' guiding control (pathological as it may have been), Miss C felt overwhelmed, overstimulated, and cut adrift. Her fragile narcissistic equilibrium was in need of a selfobject to perform the required modulating and mirroring selfobject functions.

Miss C had attempted to derive these needed selfobject functions from her male cousin's wife, but the woman had apparently found these demands to be too burdensome.

Hence, without friends and lacking the basis for a mature autonomous self, Miss C felt frightened and alone in the big city. We could say that this response might not be particularly unusual for a 19 year old young adult, under such circumstances. However, Miss C, lacking the basic self structure of many young adults, had a more intense need for people who could provide the required selfobject functions for her.

Although she was fearful of disappointment in the initial contact with the therapist, Miss C was obviously looking for the therapist to provide specific selfobject functions for her. Hence, it was not surprising that Miss C would quickly form such a selfobject relationship with the therapist.

In addition to the needed idealized parent imago functions, Miss C needed the therapist to "mirror" her grandiose self needs--to value her in the way that her mother had been unable to.

Miss C's capacity to express her fear of rejection by the therapist and her willingness to admit that she experienced greater comfort with the other therapist, might be viewed by some therapists as signs of strength. However, this therapist views these as signs of Miss C's desperation and the degree of her self pathology. That is--the urgency and intensity of the need of the selfobject function reflects correspondingly the depth of the weakness in the cohesive self.

Although Miss C came to therapy in an extremely vulnerable state, the need to turn to therapy for help did not appear to be a conflict for her or a source of narcissistic injury. Conversely, it seemed to bolster her self-esteem because both her cousin and his wife, whom Miss C idealized, were in therapy and advocated its value.

Extrapersonal Factors

The therapist learned from Miss C rather late in treatment that she hated to see the therapist's other patients coming to or leaving the office because she did not like the idea of having to share the therapist with anyone else. In fact, in the session when Miss C finally admitted these feelings, she exhibited what appeared to be a sudden regression in the treatment relationship, i.e., reminiscent of the very first session, Miss C came into the therapist's office with a fixed smile on her face and began with, "I don't know what to say."

Although this information was gleaned during a later phase of treatment, the author mentions it here to attune therapists to these possible injuries. Although in many office situations these external events cannot be prevented, if the therapist is attuned to the patient's narcissistic needs he/she can better perceive the patient's verbal or non-verbal clues of narcissistic injury.

The Case of Mr. D

Mr. D, a 24 year old Caucasian, single, male truck driver, was first seen by the therapist as an Intake at the mental health clinic. (Seeing him on Intake means that he was not referred directly to the therapist.) No

patient-therapist contact had been made prior to meeting in the clinic waiting room.

Upon meeting Mr. D, the therapist introduced herself and asked him to follow her to her office which was upstairs in an adjacent building.

Mr. D was a handsome, naturally blond, neat though casually dressed, young man. Upon entering the therapist's office, Mr. D sat down in the chair that was closest to the therapist's desk. Though he appeared to be fairly comfortable, he exhibited an expectable degree of tension as was evidenced by his body posture: he sat much of the time with his arms crossed.

Mr. D began by telling the therapist that he had considered coming to therapy for over a year because of periods of depression that would persist for one to two weeks. In fact, recently he had been so depressed and withdrawn that he had frequent crying spells, though he had no idea as to why. He said that he would turn to his mother or his sister for understanding but that nothing seemed to help. (We can imagine how distraught a 24 year old truck driver might feel about the need to turn, crying, to his mother or to his sister.) Concerned about his behavior, his sister persuaded him to see a therapist.

Mr. D said that he felt that he should be able to deal with his own problems and that he really wasn't sure

that talking to someone else would help. He further said that he knew a few people who had been in therapy for several years and that he thought that this was "foolish and unnecessary." He wanted to know how therapy would help and he let the therapist know that he did not plan to come "forever."

After addressing Mr. D's concerns about therapy and providing him with some general answers about how the process "works," the therapist then directed him to an exploration of any feelings that might underlie his current depression. Mr. D had no idea what he was depressed about. All he knew was that sometimes he felt good--even "high"--and then suddenly he would become depressed for no apparent reason. It was striking to the therapist that a young man who seemed to be basically well adjusted and non-psychotic could have such a limited amount of insight. (This was a possible diagnostic clue.)

The therapist guided the interview in a way so as to help Mr. D recount his earlier life. She learned that his parents divorced when he was eleven years old. Though he and his sister remained with the mother, Mr. D had had frequent contact with his father even up to the present time but their relationship was always superficial and Mr. D "had never felt close to him."

In fact, as Mr. D's history unfolded, it revealed that there appeared to be an egregious absence of intimate personal attachments in both his childhood and his adult life. Mr. D remembered no early figures whom he looked up to as idealizable or to whom he felt special.

His father was described as a heavy drinker, probably an alcoholic today. His mother who was described as a self-supporting, self-sustaining woman, was somewhat aloof. Mr. D recalled that his parents never seemed to be affectionate with each other or with their children.

During the earlier years before his parents divorced--when Mr. D was about age 7 to 11--he would make a point of staying at home when his father was working about the house. He said, he did not do so for the satisfaction of being with his father but because he would feel guilty if he left. Mr. D had very little insight into the source of his guilt. (It is the author's "hunch" that Mr. D desperately yearned for his father's "mirroring" attention and acceptance but that he had long since given up his conscious awareness of this wish.)

Mr. D was tearful as he recounted the story of his parents' divorce. He said that he was completely surprised that he felt so bad--that he was unaware of having these bad feelings about the divorce. He said that he felt better just knowing that there might be a reason for his depression

and that he looked forward to learning more about himself. The session ended on a rather positive note.

The third session with Mr. D began by his telling the therapist that he had previously withheld information. In the recent past he had dated a woman with whom he had a sexual relationship but that he only cared for her as a friend. She had given him an ultimatum--she wanted a commitment from him or else she would stop seeing him. Mr. D was not willing to give her this commitment so they broke off the relationship.

Mr. D said that he had not told the therapist about this sexual relationship in the previous sessions because he was concerned about what she would think of him. However, he had thought this over and decided to tell the therapist at this time "because he was not coming to therapy to impress the therapist." By way of exploring Mr. D's feelings about having such a relationship, the therapist conveyed her accepting and non-judgmental attitude about his behavior and her willingness to understand his feelings regardless of the nature of the material that he presented. It appeared that the beginning of a trusting therapeutic relationship was forming.

Discussion of Mr. D

Intrapsychic Factors

The fact that Mr. D had resisted coming to therapy for over a year but finally did at the encouragement of his sister, gives some indication of how the thought of turning to a therapist for help might be experienced as a narcissistic injury to Mr. D.

His overall state of depression, his social-withdrawal, his crying, all contributed to a state of lowered self-esteem. By turning to a therapist, all the while stating that he did not intend to be in therapy "forever," Mr. D revealed his general state of narcissistic vulnerability.

Also, it was obvious that his need to turn to a therapist was being experienced as a narcissistic injury. His expressed expectation that he should be able to deal with his own problems is further indication of Mr. D's state of wounded narcissism.

In the third session, Mr. D revealed that he had previously withheld information about his sexual activity. He said that he decided to tell the therapist because he was "not there to impress anyone." There had not appeared to be any obvious clues in the first or second session that would alert the therapist to Mr. D's concern of what the therapist might think of him. Theoretically, however, we

know that people who suffer from depression and low self-esteem generally are self-critical and frequently they project this self-criticism onto others to protect themselves against narcissistic injury.

In Kohutian terms, we might have a more complete explanation of Mr. D's depression and lack of intimate relationships. Mr. D's apparent lack of intimate selfobject relationships throughout his life, and his subsequent (possible) premorbid state of manic-depressive illness (manifested by his "highs" and his states of depression for no apparent reason) leads the therapist to speculate that Mr. D, at a very early age, split-off and isolated that part of his nuclear self that yearned for "mirroring" of his grandiose-self needs. As a result of the intensity of Mr. D's selfobject needs in childhood and because of his conviction that these needs would not be met by the parental selfobjects, he experienced deep shame which in turn led to the suppression of the wish for these needs. The outcome was depression and episodic feelings of hopelessness and emotional withdrawal.

Although the therapeutic relationship had begun to develop and had reached a point that Mr. D could risk revealing his behavior, we could not say that a true selfobject relationship had formed because Mr. D's complex self pathology does not readily allow such a selfobject tie to form.

The Case of Miss E

Miss E was a 19 year old woman who called the clinic while the therapist was on call. Miss E said that she had been to the clinic the previous day and that she had seen a male therapist whose name she could not remember. She said that she did not want to see him again and she would like another therapist. She said that she had not anticipated that the sex of the therapist would matter but that she guessed that she did not want a male therapist because she was very uncomfortable with him.

The therapist learned that Miss E had seen the male therapist on Intake--meaning that when she came to the clinic for the first time she had no idea whom she would be seeing.

(A few weeks prior to Miss E's initial appointment, the clinic, in keeping with Department of Mental Health requirements to provide DSM-III diagnoses on all five axes, had requested that all therapists complete the extensive history and mental status evaluation by the end of the first hour. See Appendix A and B.)

It was this therapist's "hunch" that Miss E was responding to this experience when she said of the male therapist, "All he did was ask me questions--he didn't want to talk about my problems and he didn't make any conclusions."

It is this therapist's conviction that the fault did not necessarily lie alone in the attitude of the therapist himself but lay partly in the fact that he felt compelled to ask so many questions, adhering to the clinic requirement for completing the DSM-III diagnoses.

Moreover, Miss E went on to add that during this initial session the therapist's phone rang and that he subsequently began asking someone else a lot of questions while he was filling out a form, so she, her anxiety mounting, stood up, told him that she had a job interview (she did but later in the day), and she departed.

In light of Miss E's apparent anxiety, this therapist referred her directly to another therapist--a female--and explained her actions to the original male therapist. Miss E, however, did not subsequently keep her appointment with the female therapist and did not call to cancel or to reschedule the appointment.

Discussion of Miss E

Intrapsychic Factors

Miss E is an example of a young woman who came to the clinic in a very high state of anxiety. The therapist did not learn the original source of her anxiety. All she learned was that it had been intensified the previous day as the result of a bad experience at the clinic.

Extrapersonal Factors

It is very likely that Miss E fell victim to the clinic procedures. In the author's opinion, because of Miss E's exceedingly high level of anxiety, the male therapist should have started the session by trying to find out what Miss E's anxiety was all about. Questions of personal and family history should have been shelved until Miss E was less anxious--later in the hour or even in the next session.

Unfortunately, clinic procedures are too often set up for the good of the clinic rather than the good of the patient. For example: The telephone interruption was most untimely. However, since the male therapist was on call he was required to answer the telephone every time it rang. Had the male therapist simply taken a name and number and told the person when he would return the call, the injury might not have been so great. It compounded Miss E's state of extreme anxiety by giving her a feeling of being also rejected. In any event, it seemed certain that because of the combination of the questions and the telephone interruptions, the patient became overwhelmed and fled.

Another possible injury might have been inflicted when Miss E inquired of the therapist whether she would be the person that would be seen. This question followed the therapist's listening to Miss E's feelings about her

previous day's experience--conveying acceptance and understanding of Miss E's request to see another therapist. It appeared that Miss E felt a positive sense of connection with the therapist, then perhaps a sense of rejection when the therapist explained that she would not be able to see Miss E in ongoing therapy.

It is little wonder that Miss E did not want to risk a third try at making a connection with the clinic.

The Case of Miss F

Miss F was a 24 year old Caucasian, single woman who came to the clinic as a walk-in just before the clinic closed. As therapist on call, the author saw her briefly to fill out a brief intake form (see Appendix A) and to arrange an appointment with her for the following day. The therapist explained that she would not be the therapist that would be seen.

Miss F had brought her older sister with her "for support." Her sister had been in therapy previously and felt that it had helped her immensely.

Miss F, an attractive, brunette woman, was extremely anxious and relied on her sister for strength. As the two sisters came into the therapist's office, they sat opposite each other and made frequent eye contact--Miss F looking for signs of approval from her sister. Miss F

said that she was depressed, unhappy and at times had thoughts of suicide. She had put off coming to therapy for almost a year but during the past two months she had felt so bad that she decided that she couldn't cope any longer by herself.

In light of Miss F's anxiety and depression and her difficulty in motivating herself to come to the clinic, the therapist was concerned about the fact that she could only see Miss F for 20 minutes. The therapist, comfortable that Miss F was not an immediate suicide risk, and empathic of Miss F's anxiety and fear, expressed to Miss F that it must feel frustrating finally to muster up the courage to come to the clinic and then be forced to wait until the next day to see a therapist. Miss F replied, "I've made the first step by coming. I'll be okay now."

Expressing her support, the sister said that she would take off work again the next day in order to come and wait with her; but Miss F said that she did not think it would be necessary.

The therapist explained to Miss F what the procedure would be when she returned. Apprehensively, Miss F asked if the Intake is where she would find out if she was to be seen in individual or group therapy. The therapist responded affirmatively but added that Miss F would have something to say about that. Miss F expressed relief and

said that it would be hard enough for her to talk to one person, let alone a whole group of people.

Her sister said that she had been seen in individual therapy before she began in a group and that she did not think that she could have gone into a group without that preparation. The therapist said to the sister that it sounded as though she felt a lot better after she came to therapy. She replied that she had. Her response had a reassuring effect on Miss F. As the session ended, Miss F reconfirmed that she would return the next day.

Discussion of Miss F

Intrapsychic Factors

The most significant sign of narcissistic vulnerability and lowered self-esteem expressed by Miss F was that she had been "depressed," "unhappy" and at times had had suicidal thoughts which had intensified during the past two months. It seemed that Miss F's reluctance to come to the clinic for over a year might be suggestive of her fear of turning to someone else for help. Her emotional state, however, had decompensated to a point where her fragile narcissistic equilibrium intensely needed a selfobject to hold her together. In this case, her older sister provided the somewhat brittle "glue."

This was a probable indication of what Miss F would require from the therapist. One could speculate that there would be considerable fear and resistance to her formation of this selfobject relationship as suggested by her waiting until her feelings were unbearable to come to treatment. If the therapist, however, would respond empathically to Miss F's vulnerable feelings and her intense needs, a self-object tie would be established and the patient's narcissistic equilibrium could be strengthened. In Miss F's case, one would expect this to be an idealized parent imago self-object attachment because of her need for merging with a calming and protective selfobject, i.e., her sister coming with her to the clinic and to the therapist's office for "support."

Extrapersonal Factors

Miss F's anxiety very likely was influenced by her sister's experience in therapy, particularly the anticipation of having to be in a group. Although Miss F's sister had had a positive experience in group therapy, Miss F felt that she could not cope with the idea of sharing her vulnerability with more than one person at a time. Very likely, Miss F's needs were of such a nature that she needed the attention of someone all to herself. It is this

therapist's opinion that referral to a group would undoubtedly result in a treatment failure.

The therapist does not know whether Miss F followed through with her appointment the following day. It appeared that Miss F's feeling that she could come to the clinic without her sister was evidence that the therapist had, at least momentarily, provided a calming, anxiety-reducing experience for Miss F. In spite of the fact that the therapist had begun the short session by saying that she could not be the ongoing therapist, a beginning relationship appeared to have been established.

CHAPTER VI

DISCUSSION OF FINDINGS

The purpose of this study has been to explore theoretically the relationship of narcissism to self-esteem and to examine closely the many ways that the vicissitudes of beginning treatment can impact on that narcissism or self-esteem.

As indicated in the Introduction to the study and elaborated on in Part 3 of the Review of the Literature, historically, most authors have recognized the fact that patients experience a non-specific narcissistic resistance in response to treatment as a whole. They have also recognized that at the beginning of treatment resistance can be significantly more intense. It is the contention of this author, however, that this resistance can be shaped and affected not only by specific intrapsychic factors but by extrapersonal factors as well--particularly at the early phase of treatment--and it is at this critical and sensitive juncture that the stage is set for possible success or failure of treatment.

In Chapter III, Part 1, a brief historical overview of the development of thought concerning the term

narcissism from Freud to Kohut was presented. It was seen that Freud's view of narcissism--that it is a negative personality trait--has perdured even to today and that the term narcissistic is commonly understood among psychotherapists and lay people as well to describe a person who is so self-absorbed that meaningful interaction and/or amelioration in treatment is extremely difficult. In this study, however, we have taken the view of Kohut who holds that narcissism (investment in the self) can also be manifested in an appropriate, non-pathological manner--and not necessarily at the expense of caring for others.

In fact, Kohut viewed most people as having in one degree or another some narcissistic vulnerability or some narcissistic features (episodic disturbances in the self-selfobject dyad) which have come in response to occasional trauma-induced injury of the mature, cohesive self.

For us, in this study, the beginning patient's degree of narcissistic vulnerability should be viewed on a continuum ranging from mild to severe, non-specific to specific, but ever-present. For the patient in beginning treatment, his or her generalized state of narcissistic vulnerability is heightened many times over when he or she suffers personal problems or narcissistic injuries so severe that he or she must turn to therapy for help. And it is the author's contention that whether the root of

problem lies in the neurotic realm or in the narcissistic realm of the personality, the issue of the person's recent narcissistic injury and the accompanying reduction of self-esteem at the critical beginning phase of therapy must be empathically addressed. Moreover, it is the author's conviction that therapists, regardless of their theoretical frame of reference, can be trained to identify or recognize descriptively signs of the patient's narcissistic vulnerability and lowered self-esteem.

The Role of Narcissism in Beginning Treatment

As we observed in the introductory chapter, in Part 3 of the Review of the Literature, and in the Case Vignettes in Chapter V, most patients come to psychotherapeutic treatment with a problem or set of problems which has generated in them a decidedly lowered state of self-esteem. This state is then compounded by the inescapable realization that the problem cannot be solved by themselves alone; they must now come to a therapist for help. At this early, vulnerable phase, the mere presence of this professional--who is perceived as superior--underscores the patient's already heightened sense of inferiority and lack of self-worth.

At this point, two major kinds of factors can impact on the patient's already lowered state:

1. Intrapsychic Factors

a. Precipitating problems that caused the patient narcissistic injury and brought the patient to treatment; and

b. Inner feelings about having to go outside himself for help.

2. Extrapersonal Factors

a. Attitudes of intake consultant and/or therapist;

b. Interview methods in the initial sessions; and

c. Setting--location or atmosphere of the office or clinic, presence of other patients.

In the following section, we will describe ways in which the therapist's alertness to these two categories of factors--intrapsychic and extrapersonal--can aid in the treatment process.

Intrapsychic Problems in Beginning Treatment

People decide to come to therapy for many reasons. Some presenting problems are specific: loss of a job, the resulting financial stress, loss of a loved one through break-up, divorce, or death, problems with authority figures, inability to deal with one's children, etc.

In other cases the symptoms may not be clear-cut. Indescribable feelings of despair, low self-esteem, lack of ambition, inability to control anger, inability to experience joy or pleasure in anything, excessive self-criticism or disappointment in others, or a basic feeling that life is passing him or her by, are all complaints that the patient may voice during the early hours of therapy.

These feelings may have become prominent as the result of a crisis, or may have been long standing. They all represent, as self psychologist Goldberg (1975) writes, "one or another form of hurt feelings, damaged self-esteem, or wounded narcissism," and stem from weaknesses in one degree or another in the mature, cohesive self.

Though at this juncture in his or her life, the patient's lack of self-esteem may be severe, he or she might attempt to mask this vulnerability in a variety of ways. For example, a person can come to the first session with a serious presenting problem about which he is feeling extremely vulnerable. Facing the therapist for the first time increases this discomfort. To deny this sense of vulnerability and inferiority, he may proceed to report to the therapist how very well he is doing. In response, the therapist might naively think: "This person indeed has many strengths; he functions well at work, at school, and in social situations. Why, then, is he here?" Remembering

the classical social work dictum to be supportive of the patient's strengths, the therapist attunes himself to the content of the story rather than to the process of the session. By taking this seemingly simple rule--be supportive of the patient's strengths--the therapist can forget the very fundamental fact that the patient may well be denying his or her real feelings out of a fear of being hurt by "looking bad" in the eyes of the therapist (see Mr. D, Chapter V, Case Vignettes, p. 95).

Too often when this same patient goes on to express doubt about his need for anything more than a brief period of treatment, the therapist unwittingly falls into the masquerade and begins to feel that perhaps this is true; the patient may need nothing more than a cursory period of treatment. Whether this doubt in the therapist's mind is expressed verbally or non-verbally, communication takes place. Hence, through this simple act of collusion, the therapist can reinforce the patient's denial of his own vulnerability and of his deep sense of shame at needing help.

By agreeing with the patient's rationalizations, the therapist can also inflict yet another narcissistic injury--one so severe, in fact--that the patient may never return for another session. Because the therapist has attuned himself to the patient's exposition of his many

strengths, the patient may actually feel still another burden. He may now fear that the therapist could never continue to think so well of him if the truth of how terrible he really feels, or of what terrible impulses he has, is ever revealed. Once again in his life, the patient now feels misunderstood. There is now no one--particularly this therapist--who can ever know and accept him exactly as he really is.

In Kohutian terms, the patient's need to paint a rosy picture of himself grew out of his need to have the therapist admire and think well of him--to mirror his grandiose self--in order to raise or to repair his self-esteem. At this critical point, the patient badly needs the therapist as a narcissistic selfojbect.

However, self psychology would urge the therapist at this time to look beyond the patient's defensive resistances to the narcissistic injury that brought him to therapy in the first place. Was it his job, his friends, his family? What was it? Moreover, in addition to seeking a descriptive account of the presenting problem, the therapist should attempt to observe how the patient is responding to him. Is he seeking the therapist's approval or admiration? Is he idealizing the therapist in order to merge with him as a calming, soothing selfobject? Further, what kind or degree of narcissistic injury, if any, has

the patient sustained from his inability to solve his own problems and his subsequent need for treatment?

Intrapsychic Factors: Implications for Treatment

As was seen in the Review of the Literature, much has been written about methodology in the initial interview or interviews. Prevailing thinking has ranged from a strict question-and-answer technique to the method advocated in this study in which data about history and mental status are obtained in a relatively unstructured way with emphasis on the patient's immediate feelings and needs.

As was illustrated in the case of Mrs. A (see Chapter V, Case Vignettes, p. 70), many beginning patients need the therapist to guide them in telling their story. Others, such as Miss B and Miss C, speak more freely without much direction from the therapist. Whatever the degree of reticence or freedom from restraint, every initial interview should flow from the patient's feelings and needs.

In many settings--particularly public clinics--procedures for the initial interviews are based on prescribed goals to obtain history, mental status, diagnosis and treatment plan by the end of the first hour. Though it is only with this package of information that we will be able to establish ultimately a realistic treatment plan with viable goals, this will be only an intellectual

exercise if the patient becomes so alienated by a barrage of impersonal questions that he does not continue in treatment. An unfortunate example of this was Miss E (Chapter V, Case Vignettes, p. 98), who fell victim to the DSM-III and clinic procedures.

In this author's opinion, there is no reason why a history, mental status, diagnosis and treatment plan has to be fully completed by the end of the first hour as required in some clinic settings. Though it is agreed that it is only with this package of information that a sufficient understanding of the patient and his problem can be obtained and a realistic treatment plan formed, the goals of treatment are constantly changing as the process unfolds. Why, then, subject the patient to a condensed, intense process of questions-and-answers so early in treatment when the material can be revealed in a less threatening manner as the trust and empathy are allowed to develop between patient and therapist?

Why indeed attempt to obtain large amounts of data during the first patient-therapist encounter when in all likelihood, at this phase, the patient will be unable to provide a full account of his present condition. At this point, it may not be that he is unwilling to disclose his presenting problem and its surrounding feelings, but that the feelings are still defended and hence unavailable to

him. Moreover, his natural resistance to beginning therapy and his heightened narcissistic vulnerability mitigate against full self disclosure to a stranger whose status has been clearly established as being far superior to his own.

At this early phase of treatment, such a patient--particularly one with pronounced weakness in his mature cohesive self--will be keenly sensitive to any of the therapist's empathic failures in the treatment session. For this person, or in fact for any person in beginning treatment, the author firmly believes that the establishment of a trusting relationship with the therapist is the single most important factor in these early hours of treatment. In fact, it is impossible to overstate the complexity of the formation of this trusting relationship--a tenuous and fragile bonding process that can sometimes take months to crystallize.

No therapist can avoid forever empathic failures in the overall treatment process. However, if the patient can feel growing trust and rapport toward the therapist in the beginning phase of treatment, he will be better able to tolerate these unavoidable errors when they do occur. Indeed, in later treatment it is via the reparation of these empathic failures that the patient who has specific deficits in his self structure utilizes the selfobject

relationship with the therapist to lead to at least a partial repair of the self deficits.

Extrapersonal Factors in Beginning Treatment

Injuries that occur as a result of the treatment setting, staff members or the therapist are grossly overlooked in the literature.

In most instances, these are extrapersonal factors over which the therapist has no control. In fact, unless he is keenly perceptive to changes in the patient's mood or affect (see List of Factors in Chapter VII), the therapist may not even be aware that something in the external treatment setting has caused narcissistic injury to the beginning patient.

Although private practice contains some of the same hazards (see Miss C, Chapter V, p. 91), extrapersonal problems are more intense and more numerous in the clinic setting. While it is true that for some chronic and dysfunctional patients, the public clinic is a familiar and helpful resource, for others it is a source of severe shame and narcissistic injury. For them, the mere fact that they must come to a public mental health clinic for treatment constitutes a serious affront to their self-esteem.

It is interesting to note that it is not uncommon for adolescents, especially those who have been coerced

into attending the clinic, to have a negative reaction to the sign in front of the building that reads, "Mental Health Outpatient Clinic." They fear that people seeing them coming and going from the facility will think that they are indeed "crazy."

Extrapersonal Factors: Implications for Treatment

As we have noted throughout this study, the mere process of becoming a patient can be a source of severe narcissistic injury. When the person is able to enter treatment on a private basis, it is relatively simple to arrange to see a therapist. The prospective patient obtains the name of a therapist from a physician, a friend, or occasionally from the telephone book or other professional listings.

Whether the therapist wills it or not, the underpinnings of the therapeutic relationship begin almost as soon as the patient obtains the therapist's name and most certainly by the time the patient makes the first telephone call. The rapidity with which the therapist returns the patient's call, his manner and his tone all will have an impact on the patient's expectations of the treatment. Parenthetically, the patient's tone and manner, plus any referral information already provided him, will impact on

the picture the therapist will be forming about his new patient.

All of this becomes immensely more complicated when a patient attempts to commence treatment in a public clinic setting.

Typically, the patient telephones the clinic blindly, not usually armed with names or data on available therapists. The patient then talks on the telephone to two or three clinic personnel before he is finally put through to the therapist who is on call for that day. After providing some basic information regarding name, address, age, presenting problem (see Appendix A) to that on-call therapist, the patient can then make an appointment to come to the clinic for his initial evaluation.

It is not unusual at this point for the patient to ask this on-call therapist if he is the therapist that he will see in treatment. However, unless the Intake appointment is set for the following week during the therapist's next on-call time, the answer will invariably be "no." Although the patient's question suggests that an attempt at a therapeutic relationship is beginning to be formed at the time of the telephone contact, that attempt will most likely of necessity be thwarted (see Miss E, Chapter V, Case Vignettes, p. 90). The patient will still be in the "woods" as to who his therapist will be until he has come

to the clinic on his assigned day and time and filled out more papers and seen the financial worker to establish the fee.

This financial interview, frequently the first personal encounter for the patient with clinic personnel, is often both distressing and embarrassing. For many patients it constitutes a double-bind in which fear of appearing too indigent is mixed with fear of appearing too affluent, hence, risking the prospect of incurring a fee that is well beyond their means.

When the patient finally does meet his therapist, other hazards can confront him.

The author's clinic provides a case in point. There, after the patient has gone through a maze of clinic personnel and at last has obtained an initial appointment with his or her therapist, he is subjected to a complex intake interview format--the DSM-III (see Review of the Literature, Part 2), which must be completed by the end of the first hour.

In order for the therapist to diagnose the patient according to DSM-III on all five axes, a basic mental status and personal history of the patient must be obtained (see Appendix B).

With some patients, this structured interview poses no serious threat of narcissistic injury. However, with

others, such as Miss E (see Chapter V, Case Vignettes, p. 98), the problem is not only severe but critical to the ongoing treatment process.

If the patient is able to sustain this initial rite of passage and can feel enough trust to return to that therapist for treatment, other possible sources of injury may await him.

At the waiting room which connects to the front office, clinic staff may receive the patient in an impersonal way. At times, unwittingly, these staff members may be overheard discussing or revealing personal information about the therapist. In the large waiting room where all patients must sit, the patient must observe other patients, some of them at times exhibiting distressing or even bizarre behavior.

When he does see his therapist, their session may be interrupted from time to time with telephone calls.

If later, the patient must cancel an appointment, or call the therapist for assistance with an acute problem, his telephone call might very likely not be returned. This could be because the therapist is out of town or otherwise unavailable--information which unsophisticated clerical staff members might fail to convey to the caller. It can also be because the therapist was not notified of his call

for several hours--perhaps not until the next day--because the message was not promptly placed in his message box.

Though it is true that at times a resistant patient might "hide" behind this bureaucratic maze to avoid contact with the therapist, in all likelihood, he will feel ultimately that the therapist has not returned his call because he simply does not care about him. Now he experiences yet another narcissistic injury which mitigates further against the formation of a trusting patient-therapist relationship.

Though the author recognizes that in a large public clinic setting, some of these problems are unavoidable, and others are not, specific recommendations for the improvement of mental health clinic delivery systems are well beyond the scope of this study. The author is recommending here, however, that therapists working in these settings should stay alert to these possible intrapsychic and extrapersonal sources of narcissistic injury in their beginning patients, and should attempt to deal with them as they are occurring.

The literature, the case material, observations gleaned during the author's years of clinical experience, all point to the fact that the patient's initial step into treatment is an anxiety-provoking and vulnerable time. In both private and public therapeutic settings, recognizing and appropriately responding to the patient's feelings

about these injuries can form a central and helpful part of the treatment process.

CHAPTER VII

LIST OF FACTORS ASSOCIATED WITH PATIENTS' NARCISSISTIC VULNERABILITY IN BEGINNING TREATMENT

The following list of questions was compiled to sensitize therapists to their patients' narcissistic vulnerability and lowered state of self-esteem during the beginning phase of treatment. In posing these questions inwardly the therapist is to look for signs of narcissistic injury--lowered self-esteem, hurt pride or hurt feelings.

1. Why did the patient decide to come to therapy now?
2. Is the patient shy, withdrawn, self-deprecating? (or the direct opposite?)
3. Does he or she show a facade of arrogance, aggressive, domineering and competitive behavior?
4. What losses has the patient suffered? Loss of job, friend, loved one?
5. Does the patient have difficulty relating to peers or administrative figures?
6. Is the patient suffering from loss of self-esteem due to financial stress?

7. Does he or she feel empty and unloved?
8. Does he or she lack ambition?
9. Does he or she experience indescribable feelings of despair?
10. Does he or she frequently feel disappointed in others?
11. Does the patient feel that life is passing him or her by?
12. Is the patient unable to experience joy, pride and enthusiasm about his or her achievements?
13. Does the patient express doubt about his or her need for therapy?
14. Does he or she seek reassurance?
15. Does the patient intellectualize when talking about his or her problem?
16. What is the patient's physical posture like in the session? Is it erect, stiff, jerky, or overly relaxed?
17. Does the patient express direct or indirect feelings of anger or hurt?
18. Does he or she make positive or negative comments about the clinic or office setting?
19. Does the patient come late, early, or on time for his or her appointments?
20. Does the patient cancel appointments?
21. Does the patient leave a message to cancel or does he or she ask to speak with the therapist?

22. How does the patient respond to the fee?
23. Does the patient come to the session in an angry mood that seems out of context with what he or she is talking about?
24. Does it seem that nothing you say is the right thing?
25. Does the patient's mood or affect change during the session?
26. Does the patient suddenly become more withdrawn as though he or she were not there?
27. How does the patient feel about needing help?
28. How does the patient respond to exposure of his or her imperfections to the therapist?
29. Does he or she suffer from shame and/or humiliation about the need for help?
30. Does the patient show signs of wanting to make a favorable impression by talking more about his or her strengths than weaknesses?
31. Does it appear that the patient is withholding information?
32. Is the patient exceedingly anxious or overly calm in the session?
33. Does the patient manifest physical signs of anxiety, i.e., shakiness, unusual perspiration, sighing?
34. Do the patient's family and peers feel that therapy is an acceptable form of problem solving?

35. Do the patient's socio-economic and cultural environment support the idea of therapy as a form of problem solving?
36. Particularly at the clinic, what contacts did the patient have with ancillary staff?
37. Did the patient observe the therapist interacting with other patients or staff? Are there any resulting verbal or non-verbal clues such as quietness, lack of anything to talk about or unusual chit-chat?
38. Was the session interrupted by a telephone call or a knock at the door? Did the patient's affect or mood change?
39. During the initial interview at the clinic, does the patient appear to be satisfied with answering fact-gathering questions or does the patient seem to be desperate to focus on his or her own present problems?

CHAPTER VIII

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Purpose

All too often the patient's heightened state of narcissistic vulnerability is overlooked as a critical dimension in the beginning phase of treatment. As a result, many patients turn away from treatment before they can receive the help that is needed.

In this study the author sought to sensitize therapists to the variety of factors which can impact on their patients' narcissistic vulnerability and lowered self-esteem in the beginning hours of treatment. By identifying these factors for therapists and indicating how these factors can be recognized in the therapeutic session, the author hopes that clinicians and administrators will be better able to aid patients through this difficult phase of treatment.

Methodology

To investigate the research question, "What are the specific factors in the beginning phase of psychotherapeutic treatment that are associated with the person's heightened state of narcissistic vulnerability?," an

heuristic retrospective design was utilized. The data consisted of a review of the relevant psychoanalytic and social work literature, clinical case vignettes, and the author's own professional experience and judgment.

Theoretical Frame of Reference

For the purpose of this study, Kohut's theory of self psychology provided a useful framework with which to examine the vicissitudes of beginning treatment. Unlike Freudian theory which would hold that patients' narcissistic resistance to beginning treatment for the most part is derived from unconscious, drive-related conflicts, Kohut held that the patients' apparent resistance to treatment is derived from fear of narcissistic injury. This self psychological approach, employed in this study, supports the author's contention that narcissistic vulnerability in beginning treatment can emanate not only from the pathological realm of the personality but from the normal realm as well, e.g., even the relatively healthy and well-functioning person is susceptible to narcissistic injury during times of severe stress, anxiety and loss. Coming to therapy can compound such a stressful state, now making it necessary for the distressed person to turn outside himself and toward another for help.

Review of the Literature

Based on the constituents of the question, the literature was divided into the three following subject areas:

1. Narcissism: as formulated by Freud, Kohut, and their respective followers.

2. Beginning Treatment: Paramount Issues.

3. Narcissistic Vulnerability in Beginning Treatment.

The literature indicated that there are numerous complex meanings of the term narcissism. The significant theme is that though Freud held that narcissism was a negative personality trait resulting from a defensive withdrawal from objects, his followers, such as Hartmann, Jacobson and Mahler, believed that narcissism or self-love is not necessarily a negative personality trait. In fact, they believe that a person must first love himself before he can love or invest himself in others.

It was not until Kohut, however, and the development of self psychology, that narcissism and the ubiquitous role of selfobjects were viewed as an ever-present phenomenon in all people.

The literature on the beginning phase of treatment indicated two basic schools of thought on the ways in which therapists should first approach patients in the clinical

setting. The first and oldest school emanated from the medical model in the strictest sense of the phrase. These thinkers thought that the initial interview was for the expressed purpose of obtaining information and a proper diagnosis. The question of the patient-therapist relationship was not considered to be an issue.

The second school which evolved during the past four decades advocates an unstructured interview method with the primary focus on the patient-therapist relationship.

Authors advocating this approach argue that a structured, data-collecting, fact-finding interview leaves little room for discovery and expression of the patient's immediate feelings and needs. It allows for little manifestation of therapist-empathy with the patient--a failure which is seen more often than not to result in patient dropout from treatment. This point of view is particularly relevant to clinical social workers, ideally grounded in basic social work principles such as the intrinsic worth and dignity of the individual, the therapist's accepting and non-judgmental attitude, the client's right to self-determination and meeting the client where he or she is.

In the section of the literature on narcissistic vulnerability in beginning treatment, there were numerous indirect references to the topic dating back to 1942. For the most part, authors addressed this topic in terms of

the resistance, fear or anxiety on the part of the patient to the initiation of the treatment process. However, it was not until the emergence into prominence of Kohut and his followers in the 1960's and onward that the issue of narcissistic injury in response to beginning treatment was addressed.

Findings and Conclusions

This was a research-biased, heuristic study and therefore inconclusive. However, the data all suggest that patients are in a heightened state of narcissistic vulnerability in beginning treatment. When the research question of this study was posed, "What are the specific factors in the beginning phase of psychotherapeutic treatment that are associated with the patient's heightened state of narcissistic vulnerability?," it was seen from the findings of the literature, from the clinical case vignettes, and from the author's observations based on her professional experience and judgment that factors both internal to the patient (intrapsychic) and external to the patient (extrapersonal) can have a profound and exacerbating effect on the patient's already intensified loss of self-esteem at the beginning phase of treatment.

It was seen also that when therapists failed to recognize the patient's signs of narcissistic vulnerability

at this critical phase of treatment, an empathic failure occurs, inflicting a further narcissistic wound on an already injured or vulnerable patient. The most drastic outcome of such a situation is the patient's precipitous discontinuance of the treatment.

In presenting a compiled List of Factors (see Chapter VII), the author attempted to equip therapists with a tool for recognizing and dealing with early signs of narcissistic vulnerability and injury as they are occurring. It is hoped that, thus fortified, therapists could both prevent premature withdrawal from treatment and assist the patient to discover within him or herself those areas which are in most need of scrutiny and repair.

Implications for Clinical Social Work Practice

Even though this study has focused on patients seen in private practice and in public mental health settings, the author wishes to emphasize her belief that the findings of this study are applicable to individuals seen by clinical social workers in any public or private clinic, agency or hospital setting.

It has been the author's hope that, through this study, therapists as well as administrators in all of these settings will be able to develop keener awareness and understanding of their patients' narcissistic vulnerability in

beginning treatment, thus enabling them to deal more effectively with these new patients and consequently reduce tendencies toward treatment withdrawals.

Whenever possible, clinic agency or hospital procedures, specifically those relating to the Intake process, should be revamped better to meet the needs of the patient.

Similarly, clerical staff in any of those settings should receive training which can sensitize them to the patient's extreme sensitivity and insecurity at the time of beginning treatment. Clerical staff should also be trained to handle telephone calls and messages in such a manner as to enhance rather than disrupt the patient-therapist relationship.

Recommendations

This study has raised a number of questions and issues which are suggestive of further study. In light of the significant number of treatment failures during the beginning phase of treatment, the author recommends further and more conclusive research into the reasons that lie behind these treatment failures, particularly in the clinic setting. An important aspect of that study would be to determine more precisely what extrapersonal factors impact the patient and the overall treatment process and in what ways.

Intrapsychic factors should be studied further as well. Procedures concerning clinic interview methods, particularly the DSM-III interview format, should be scrutinized with the view of expanding the data-gathering process over more than one treatment session. Though inconclusive and selective, the author's List of Factors might be expanded and/or tested on various patient populations in a larger variety of both clinic and private settings. Comparisons might also be made via these questions between degrees of narcissistic injury suffered by patients in a clinic versus patients in a private setting.

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APPENDIXES

APPENDIX A

MENTAL HEALTH OUTPATIENT SERVICE
INTAKE INFORMATION

Name _____ DOB: _____ DATE _____

Address _____ _____ _____ _____ _____
(No.) (Street) (City) (State) (Zip)

Income: _____ No. Depend. on Income _____

Names and Ages _____

Telephone _____ _____
(Home)

_____ _____
(Work)

_____

Marital Status:

Sgl. Marr. Wid. Div. Sep.

Referral Source _____

Previous Treatment
at clinic: _____ _____
No Yes

If Yes: _____
Inpatient Outpatient

Comments on Problem:

_____ _____
Intake Worker Signed

MCW		Therapist	
Appt. Date		Appt. Date	
Day		Day	
Time		Time	

DISPOSITION:

Group _____

Individual _____

Referred Out _____

Transfer To _____

Please return form to clerical staff after intake procedure. Thank you.

APPENDIX B

INTAKE EVALUATION

NAME: _____ DATE: _____ CASE #: _____

Demography (age, sex, race, marital status, occupation and referral source):

Presenting problem(s) (onset, duration, disability):

Psychiatric history (previous treatment, hospitalizations, suicide attempts, family history of mental illness, etc.):

Pertinent medical history (include substance abuse, coffee, tobacco use, allergies, any medical problems and medications):

Personal and social history (family, living arrangements, educational, sexual, marital, legal, financial history):

Mental Status Examination:

Appearance and Behavior:

Sensorium: (memory, orientation, intelligence, insight, judgment):

Mood (include depression, suicidal or violent tendencies):

Thought process (include associations, flight of ideas, pressure of speech, paranoia, etc.):

Diagnosis (DSM III):

Axis I

Axis II

Axis III

Axis IV

Axis V GAS: _____

Treatment Plan (include problem list, goals, recommended treatment, and estimated duration of treatment):

Referral and/or consultation:

Signature _____ Date: _____